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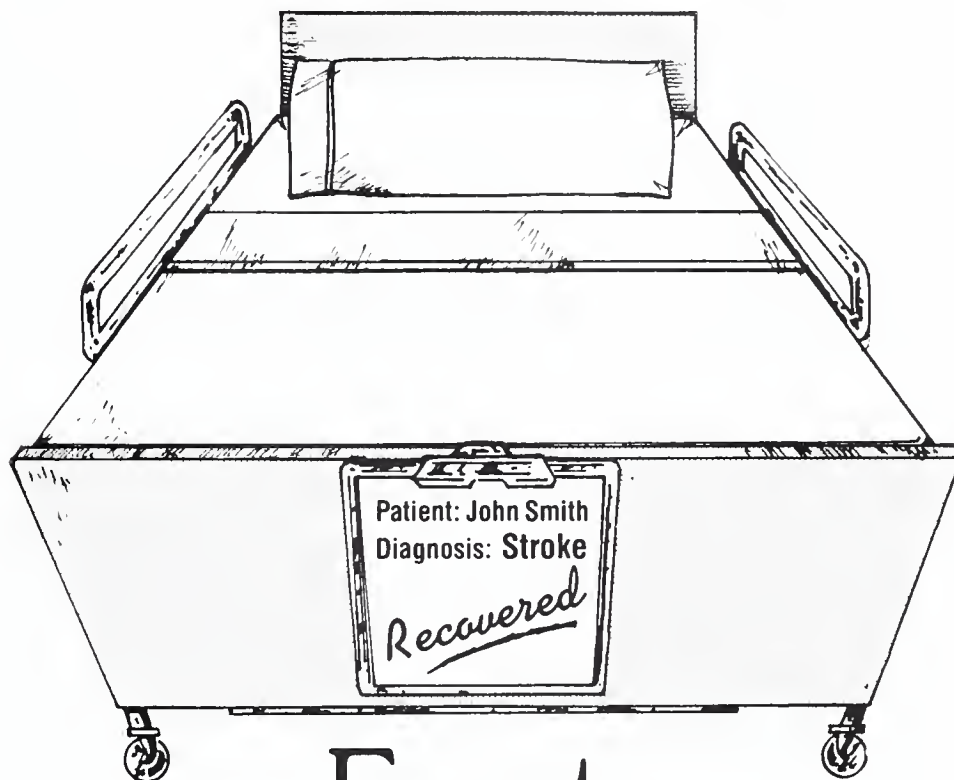
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*This month's cover introduces a special article on releasing patient medical records which begins on page 14. Design by Lee Wade of Louisville.*

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# Where there's smoke...there may be bronchitis



"Recent research has delineated early, more subtle changes in lung and immune functions. These alterations directly predispose smokers to respiratory tract infection."

*Am Fam Phys* 1987;36:133-140

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#### Brief Summary.

Consult the package literature for prescribing information. Indication: Lower respiratory infections, including pneumonia, caused by *Streptococcus pneumoniae*, *Haemophilus influenzae*, and *Streptococcus pyogenes* (group A  $\beta$ -hemolytic streptococci).

Contraindication: Known allergy to cephalosporins.

Warnings: CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

#### Precautions:

- Discontinue Cefclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of non-susceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Cefclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Cefclor penetrates mother's milk. Exercise caution in prescribing for these patients.

#### Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:

- Hypersensitivity reactions have been reported in about 1.5% of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions have been reported with the use of Cefclor. These are characterized by findings of erythema multiforme, rashes, and other skin manifestations accompanied by arthritis/arthralgia, with or without fever, and differ from classic serum sickness in that there is infrequently associated lymphadenopathy and proteinuria, no circulating immune complexes, and no evidence to date of sequelae of the reaction. While further investigation is ongoing, serum-sickness-like reactions appear to be due to hypersensitivity and more often occur during or following a second (or subsequent) course of therapy with Cefclor. Such reactions have been reported more frequently in children than in adults with an overall occurrence ranging from 1 in 200 (0.5%) in one focused trial to 2 in 8,346 (0.024%) in overall clinical trials (with an incidence in children in clinical trials of 0.055%) to 1 in 38,000 (0.003%) in spontaneous event reports. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy; occasionally these reactions have resulted in hospitalization, usually of short duration (median hospitalization = two to three days, based on postmarketing surveillance studies). In those requiring hospitalization, the symptoms have ranged from mild to severe at the time of admission with more of the severe reactions occurring in children. Antihistamines and glucocorticoids appear to enhance resolution of the signs and symptoms. No serious sequelae have been reported.
- Stevens-Johnson syndrome, toxic epidermal necrolysis,

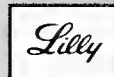
and anaphylaxis have been reported rarely. Anaphylaxis may be more common in patients with a history of penicillin allergy.

- Gastrointestinal (mostly diarrhea): 2.5%
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
- Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1% and, rarely, thrombocytopenia and reversible interstitial nephritis.

#### Abnormalities in laboratory results of uncertain etiology.

- Slight elevations in hepatic enzymes.
- Transient lymphocytosis, leukopenia, and, rarely, hemolytic anemia and reversible neutropenia.
- Rare reports of increased prothrombin time with or without clinical bleeding in patients receiving Cefclor and Coumadin concomitantly.
- Abnormal urinalysis; elevations in BUN or serum creatinine.
- Positive direct Coombs' test.
- False-positive tests for urinary glucose with Benedict's or Fehling's solution and Clinistest<sup>®</sup> tablets but not with Tes-Tape<sup>®</sup> (glucose enzymatic test strip, Lilly).

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# Order in the Court

In October 1990, the Kentucky Supreme Court held unconstitutional the medical malpractice statute of limitations which had barred the filing of lawsuits more than 5 years after any alleged negligence took place. That wasn't a total shock since the 1985 Court had ruled unconstitutional a similar statute relating to architects and engineers. In 1989, the same Court decided that Kentucky's Confidentiality of Peer Review statutes could not pass Constitutional muster. More than a decade ago, the Court found a substantial portion of the 1976 KMA tort reform package unconstitutional.

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***“Some argue, with increasing persuasiveness, that the judiciary frequently undermines legislative intent in an attempt to establish itself as the final arbiter not only of legal matters, but also of social issues in America.”***

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Some argue, with increasing persuasiveness, that the judiciary frequently undermines legislative intent in an attempt to establish itself as the final arbiter not only of legal matters, but also of social issues in America. Of late, criticism has been specifically directed at Kentucky's court system. But the Commonwealth is not alone. Take a look at other states and you'll find that Kentucky jurists are merely

falling in line behind their brethren. It's simply a matter of pace, and unfortunately, with recent changes in the makeup of our state Supreme Court, that pace may increase rapidly. Commentators have noted that our highest Court is moving sharply to the left, with a plaintiff-orientation that broadcasts bad news to the defense bar and those they represent.

The driving force for “judicial legislation” appears to be a desire to establish a “social conscience welfare system” under the rubric, “If I get hurt — somebody ought to pay.” It becomes a mechanism for redistributing dollars rather than meting out justice. Those who through industry and foresight insure against defined risks find themselves targets for unforeseeable and seemingly ludicrous claims.

The Kentucky Constitution was adopted in 1891, a turbulent era when timber, coal, railroad, and industrial interests operated with impunity. Those interests frequently ignored people's individual and property rights. Unfortunately, the document spawned by those rough times is viewed by many as sacrosanct, or as one judge recently labeled it, “The Ark of the Covenant.” Yet it lacks the malleability that is the hallmark of the US Constitution and has been relied on frequently to undermine a variety of legislative initiatives.

As noted earlier, liability or tort reform legislation has been one such target. Nevertheless, KMA, along with business and other interested groups, continues to pursue reform and remains committed to amending Section 54 of Kentucky's Constitution. Unfortunately, in “one fell swoop,” seven men can undo what others worked for years to accomplish. Even if we are successful in altering that provision of the Constitution, I fear the Judiciary may rely on other sections to handcraft additional obstacles to reform.

What does all this mean and




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***“The driving force for ‘judicial legislation’ appears to be a desire to establish a ‘social conscience welfare system’ under the rubric, ‘If I get hurt — somebody ought to pay.’”***

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**“The Kentucky Constitution was adopted in 1891, a turbulent era when timber, coal, railroad, and industrial interests operated with impunity. . . . Unfortunately, the document spawned by those rough times is viewed by many as sacrosanct, or as one judge recently labeled it, ‘the Ark of the Covenant.’”**

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what, if any, recourse do we have? I suggest several things for your consideration. Urge Kentucky Forward, a business oriented group organized to increase the effectiveness of the Kentucky General Assembly, to monitor judicial races, provide philosophical profiles and summarize precedent-setting cases directly affecting business. Make this data available in future judicial campaigns to educate the public and enable them to make informed choices. While Federal judges are appointed for life, state judges must periodically face the electorate. Follow them as they step into the political arena. Armed with an awareness of a candidate's legal philosophy, you will become a much more effective participant in the electoral process. Unless we take this situation seriously there will only be more bad news in the coming months and years. An educated electorate, through individual political action, must work to resolve this dilemma.

**Preston P. Nunnelley, MD  
KMA President**

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# **Health Access America**

The AMA proposal to  
improve access to affordable,  
quality health care.

# “I can’t afford to go to the doctor.”

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Simply, *Health Access America* proposes health insurance coverage

for all Americans, regardless of income or health status. It calls for expanded publicly-funded health care for the needy; a stronger Medicare system; employer-provided coverage for all workers and their families with tax incentives for small businesses.

America’s physicians are leading the way to reforming the health care system by speaking out on these critical issues.

To get a copy of the *Health Access America* proposal, please call our Member Service Center at 1-800-AMA-3211.

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## Cost Consciousness

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***“... the cost of medical care, fueled by ever expanding new technologies, continues to rise. Most of these costs are generated by physicians' orders.”***

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One of the hottest topics on the national scene now is the cost of medical care. Congress struggles and struggles to find ways to reduce the cost of Medicare (DRG, etc). Third party payors struggle and struggle to find ways to save money. Hospital admissions must be screened for approval. Certain surgical procedures are mandated as outpatient procedures. Most patients for elective major surgery now come into the hospital on the day of surgery and are granted insurance coverage for only a certain number of days. Etc, etc, etc.

These measures have had an impact, but the cost of medical care, fueled by ever expanding new technologies, continues to rise. Most of these costs are generated by physicians' orders. It is we who order most all the things that cost money. We order the x-ray studies, the ABGs, the CT scans, the drugs, the utilization of ICUs, TCUs, & CCUs, the laboratory tests, etc. We order these things purely and simply for the benefit of our patients. That is good. But most of us do it without having any earthly idea of how much what we are ordering costs. I have a sneaking idea that most of us would be a little less cavalier in ordering a lot of things if we knew how much they cost. For example, we might order a few less arterial blood gases if we realized each one costs \$50.50. This is not to say that we would deprive our patients of proper care — we just might be a little more discriminating.

Which brings me to this suggestion. Let's make readily available at nurses' stations and in doctors' lounges the cost of things — hospital days including the special units, x-rays, lab tests, drugs, respiratory therapy, etc. It might make a big difference.

**McHenry S. Brewer, MD**



## *Journal* Bids Farewell to Dr Paul Grider

**D**r Paul Grider has left the Kentucky Medical *Journal* Editorial Board after 15 years of service. Service is surely the appropriate word for this time given to all of us. There will be others of us to succeed him, but none of us can replace him. The mark of a real contribution is that it is beneficial, and that it need not be copied, only nurtured.

Success in athletics and academics, then in medicine, was breeding ground for participating in the challenge of medical journal editorship. Paul sensed the readership's need for information that was both valid and appropriate. His scientific proficiency and his inherent fairness made him an appropriate front line in judging material for publication. Economic medicine, with insurers and so called "providers," was unwelcome and ignited debate among us as to how much of this information should be infused into our publication. Never one to avoid controversy, Paul represented his point of view clearly and with distinction.

All this describes what happened between Paul and us. It in no way captures what was the chemistry. Thank you, Paul, for being with us and for your guidance as to what we should be doing now.

**Stephen Z. Smith, MD**



# Release of Patient Medical Records

## Introduction

Physicians and their office staffs are frequently presented with questions about the ownership, release, and retention of patients' records. This article reviews and updates the subject in light of recent court decisions. It has been prepared by Charles J. Cronan IV, Esq, legal counsel, with the assistance of Lissa Wathen, Esq, both with the law firm of Stites & Harbison.

### I. OWNERSHIP OF MEDICAL RECORDS

Original medical records are the physical property of the physician or the health care facility that provides care to the patient. However, the physician or facility is not considered to "own" the information contained in the records. It is the position of the American Medical Record Association, the AMA's Council on Ethical and Judicial Affairs, and most courts that patients have a right of access to the information in their medical records, except in limited circumstances. The original record and originals of any reports in the record need not and should not be surrendered.

### II. CONTENT OF MEDICAL RECORDS

The physician has discretion as to what information and documents to include in the patient's medical record file. Generally, it is a good idea to include only such things as the medical history, updated medical chart, reports of consultants, laboratory reports, and the like in the medical file. Billing records and other "business" aspects of the patient's care should be separately maintained. However, if

separate files are maintained, in responding to a subpoena or request for records, care should be taken to include all the items specifically requested.

Care should also be taken to avoid uncomplimentary comments (such as referring to the patient as a "crock") in the chart. These may prove embarrassing, to say the least, if the documents must be produced.

### III. PATIENT'S RIGHT OF ACCESS TO RECORDS

Given the generally recognized right of access to one's own medical records, health care providers should furnish a patient with a copy of the record or a summary of its contents when the patient makes such a request. The request should include adequate verification of the requesting patient's identity. Only when a physician makes a reasonable determination that releasing the contents of the medical record to the patient may result in physical or mental harm to the patient or cause danger to some third party should the information be withheld by the physician. Although there is no federal or Kentucky statutory law that specifically grants every individual the right to access his own medical records, there is no law prohibiting access either. Some federal and state laws do, however, expressly grant access rights applicable to specific circumstances. For example, the federal Privacy Act, 45 CFR 5b, recognizes an individual's general right of access to medical records maintained by the Department for Health and Human Services and any of its agencies, including VA hospitals and Medicare and Medicaid intermediaries and carriers. Kentucky regulation, 908 KAR

3:010, expressly provides for a mentally ill or retarded patient to have access to his entire records upon written request, unless the provider provides written documentation of specific reasons for the refusal.

### IV. CHARGES FOR COPIES

It is acceptable for a health care provider to charge the actual cost for preparing copies of medical records for the patient when requested to do so. This cost would include the copying cost and some reasonable estimate for support staff time in preparing the copies. It is not acceptable to charge for profit.

### V. REFUSAL IN VIEW OF UNPAID BILL

The AMA's Council on Ethical and Judicial Affairs has stated that it is unethical conduct for a physician to withhold the release of a patient's medical record when the patient has an outstanding balance with the provider.

### VI. PARTIES WHO MAY REQUEST ACCESS

A competent adult patient may request his or her own records. In the case of minor or incompetent patients, the parent or legal guardian of the patient may request the records on the patient's behalf. If the minor is a child of divorced parents, the custodial parent is responsible for health care. If necessary to determine which parent has custodial authority, a copy of the final court-ordered settlement decree explaining custody rights could be requested for the file. If the patient is deceased, the personal representative of the estate may request the records.



## Patient Medical Records

VII. **RELEASE TO THIRD PARTIES**

A valid authorization or release from the patient should accompany any request to release information from the patient's medical record to third parties, including the patient's attorney. The release does not have to be notarized. Ideally, the release should contain:

1. the patient's full name, address, and date of birth;
2. the name and address of the provider who is to release the record;
3. the individual or entity to which the record is to be released;
4. the specific information being requested;
5. the date the release is signed; and
6. the signature of the patient or his legal representative.

There should be no disclosure beyond the scope of the information authorized for release and no redisclosure of the same information to anyone other than the recipient named in the release. See paragraph XIV for special requirements pertaining to the disclosure of HIV test results.

VIII. **SPECIAL CONSIDERATIONS FOR PSYCHOLOGICAL OR SUBSTANCE ABUSE, AND SEXUALLY TRANSMITTED DISEASE RECORDS**

As noted in paragraph VII above, the patient's authorization should include the specific information to be released. This is particularly true when psychological or psychiatric records, which are privileged under Kentucky law, are included in the patient's file, and when drug or alcohol treatment records from federally supported programs are included. Kentucky Revised Statutes (KRS) 319.111 and 421.215;

42 C.F.R. 2. If these records are to be released, the authorization must specify them rather than attempting to include them within the scope of an authorization to release "all the patient's records," or some similar general language. Similarly, records containing reference to sexually transmitted diseases should not be released without specific authorization. KRS 214.420. See the discussion in paragraph XIV pertaining to special procedures which must be followed in releasing information pertaining to positive HIV test results.

IX. **RELEASE TO HEALTH INSURERS**

Generally, patients have authorized third party payors to obtain copies of their medical records as a condition of their participation in the insurance program. Nevertheless, it would be appropriate to request that an insurer send a copy of the authorization so that the treating provider can keep this copy in the patient's medical file. A general rule would be to confine the release to information related to the particular claim for coverage.

In contracting with third party providers, physicians are often asked to agree to produce medical information about their patients or to make the records available for inspection by the third party. The physician should always seek assurances in the contract that a third party must first obtain the patient's written consent to such disclosures.

X. **RELEASE OF X-RAYS**

X-rays are treated like other medical records. A copy should be provided to the patient or to third par-

ties upon proper request when the patient's identity has been verified, but the original need not and should not be surrendered. The patient may be assessed the reasonable actual cost of the reproduction.

XI. **RELEASE PURSUANT TO SUBPOENA**

Generally, a subpoena for production of medical records, also called a "subpoena duces tecum," need not be accompanied by a patient authorization in order to require the subpoenaed provider to release the medical record. When a person has put his medical condition in issue as the subject of a lawsuit a separate authorization for release of the relevant medical records to the parties involved is not generally required. However, the subpoena should be accompanied by a "notice of deposition" which indicates that both sides of the relevant litigation will have notice of the records request. It should be noted, though, that the special considerations regarding psychiatric, psychological, federal substance abuse program, and sexually transmitted disease records still apply. If these kinds of records are subpoenaed, a valid patient authorization specifying them should accompany the subpoena. Special rules, applicable to court orders which seek the disclosure of HIV test results, are discussed in paragraph XIV.

XII. **TIME LIMITATIONS ON A RELEASE**

There is no legal requirement that most authorizations to release medical records be or are valid only for a limited amount of time. There is one exception, however, when records are requested from

a drug or alcohol treatment program that receives federal funding. A federal statute, 42 C.F.R. § 2.31, requires that the release of these kinds of records also include a specific date, event or condition on which the authorization will terminate. Some health care facilities also have institutional policies under which they will not honor a release beyond a certain period, such as 60 days or 6 months.

### XIII. RETENTION OF MEDICAL RECORDS

Health care facilities, including primary care centers, personal care homes, nursing homes, and others, are required by the provisions of Kentucky regulation 902 KAR 20 to maintain medical records for 5 years following the last treatment or entry. The state Medicaid program also imposes a 5 year retention period for documentation of all services billed to the state medical assistance program. 907 KAR 1:007. Kentucky law does not prescribe a required retention period for physicians' medical records. Before the decision of the Kentucky Supreme Court in *McCollum v. Sisters of Charity* in October, 1990, the ban on medical malpractice suits by competent adults more than 5 years after an event strongly suggested a minimum 5 year retention period for records on adult patients. However, the court in *McCollum* held unconstitutional the 5 year "cap" on malpractice suits. As a result, prudence dictates retention of records on competent adults indefinitely.

In the case of minor patients the records should be retained at least until the child reaches the age of 19. Again, however, because of the *McCollum* decision it

would now be wise to keep them indefinitely, as with the records of adults. The records of mentally incompetent or disabled persons also should be kept indefinitely.

### XIV. SPECIAL REPORTING REQUIREMENTS, INCLUDING HIV TEST RESULTS

The generally confidential nature of a patient's medical record yields to the public health interest in certain instances. Kentucky law prescribes by regulation, 902 KAR 2:020, that certain diseases are designated as "Reportable Diseases" which must be reported to the local county health department when diagnosed. Some must be reported within 24 hours and others within 7 days. The reporting requirements include, in addition to certain clinical data, the name and address of the patient. Sexually transmitted diseases may generally be reported using a re-identifiable code number in lieu of the patient's name and address.

The 1990 Kentucky General Assembly also adopted AIDS legislation which protects the physician against civil and criminal liability for disclosure of otherwise confidential information. KRS 311.282 protects a physician who reasonably and in good faith advises a spouse or sex partner of a patient (who has cohabited with the patient for more than a year) that the patient has tested positive for the HIV virus.

Court orders seeking the release of information about HIV test results are effective only if they comply with KRS 214.625(9). The order must specify the persons who may have access to the information, the purpose for which it shall be used, and appropriate prohibitions against further disclosure.

When disclosure is made, it must be accompanied by a written statement that:

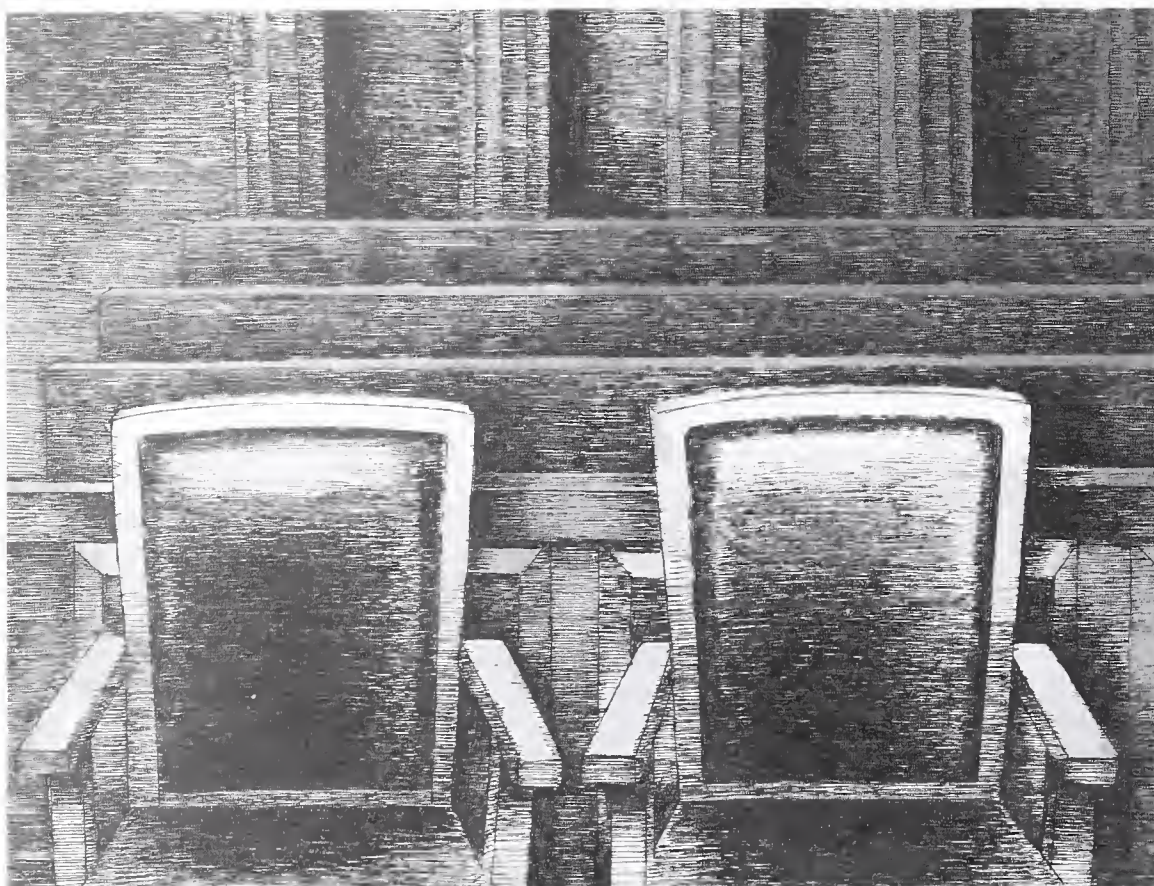
This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of such information without the specific written consent of the person to whom such information pertains, or as otherwise permitted by state law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

[KRS 214.625(9) (e)]

Another example of permitted disclosure occurs when an individual with a seizure condition applies for a driver's license. This individual must present a physician's certification that the condition is controlled by drugs and a physician is shielded from civil and criminal liability when he provides this information in good faith. KRS 186.411.

Similarly, physicians are required to report but are protected from liability for good faith reports of child abuse or neglect. KRS 620.030-050.





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# HLA Type and the Genetic Risk for Type 1 Diabetes Mellitus

Duncan R. MacMillan, MD; Michael B. Foster, MD; Mary P. Key, MS

*One hundred twenty-nine type 1 diabetic children and 176 non-diabetic siblings from the Louisville referral area were HLA typed by microlymphocytotoxicity technique. DR antigen frequencies were compared to frequencies for the Southeast USA population. Frequencies of DR3 and DR4 were significantly increased in both the diabetics and their unaffected siblings relative to the general population and DR2 was decreased. Forty-six percent of diabetic children possessed both DR3 and DR4 antigens while only 7% had neither. The findings are consistent with those in other geographical areas and give strong support to the role of DR3 and DR4 antigens as markers for diabetes susceptibility genes.*

The inheritance of diabetes, once considered "a geneticist's nightmare," has been greatly illuminated in the past decade. The clear distinction of insulin-dependent (type 1) diabetes (IDDM) from non-insulin-dependent or insulin-resistant (type 2) diabetes has allowed a much sharper focus on the genetics of type 1 diabetes, the common form of diabetes in children.

Tissue typing of insulin-dependent diabetics requiring renal transplantation provided early indications of the role of antigenic alleles of the major histocompatibility complex (MHC), located on chromosome #6, as genetic markers for diabetes susceptibility. Extensive investigation of associations of histocompatibility (HLA) antigens with IDDM, initially focusing on the class 1 antigens at the A, B and C loci, but later extending to the less easily demonstrated class 2 antigens at the D locus, indicated that two distinct groups of interrelated HLA antigens were clearly associated with an increased risk for IDDM. These groupings (haplotypes) were identified as: A1, B8, DR3 and A2, B15, DR4 with associations at the D locus being strongest and at the A locus weakest.<sup>1</sup> It is now universally accepted that the primary

associations with IDDM reside within the D locus and that associations with A and B antigens exist only through linkage disequilibrium with corresponding D antigens. Sub-loci of the D region designated DP, DZ, DO, DX, DQ and DR have been elucidated, and while the DR alleles DR3 and DR4 are the most widely accepted markers for IDDM, recent molecular genetic studies indicate that certain alleles at the DQ locus have the highest degree of IDDM association and may represent the true diabetes susceptibility genes.<sup>2</sup> Because of the technical difficulty in performing DQ typing, DR typing will probably remain the primary genetic screening tool for IDDM for the foreseeable future.

Population data on DR frequencies for IDDM patients and individuals at large are available for many parts of the world, including several regions of the USA.<sup>3,4</sup> We have attempted to define the frequencies of the various DR alleles in diabetic children and their families in the Louisville referral area and make comparisons with the southeast USA population statistics obtained through the courtesy of the Kentucky Organ Donor Affiliates.

## Methods

Children being followed for insulin-dependent, ketosis-prone diabetes mellitus in the private office and clinics of the University of Louisville School of Medicine, Department of Pediatrics, were recruited along with their non-diabetic siblings according to a protocol approved by the University of Louisville Human Studies Committee.

One hundred twenty-nine diabetics and 176 non-affected full siblings were HLA typed with respect to the A,B,C and DR loci by lymphocytotoxicity microtechnique using plates obtained from the laboratory of Dr Paul Terasaki, Los Angeles, CA. Only DR data are presented here. Five diabetics and 9 unaffected siblings were from black families; the remainder were of Caucasian origin.

*From the Department of Pediatrics, University of Louisville School of Medicine, Louisville, KY 40292. Dr MacMillan is Professor and Director and Dr Foster is Associate Professor of Pediatric Endocrinology. Ms Key is Senior Research Technologist in Pediatric Endocrinology.*



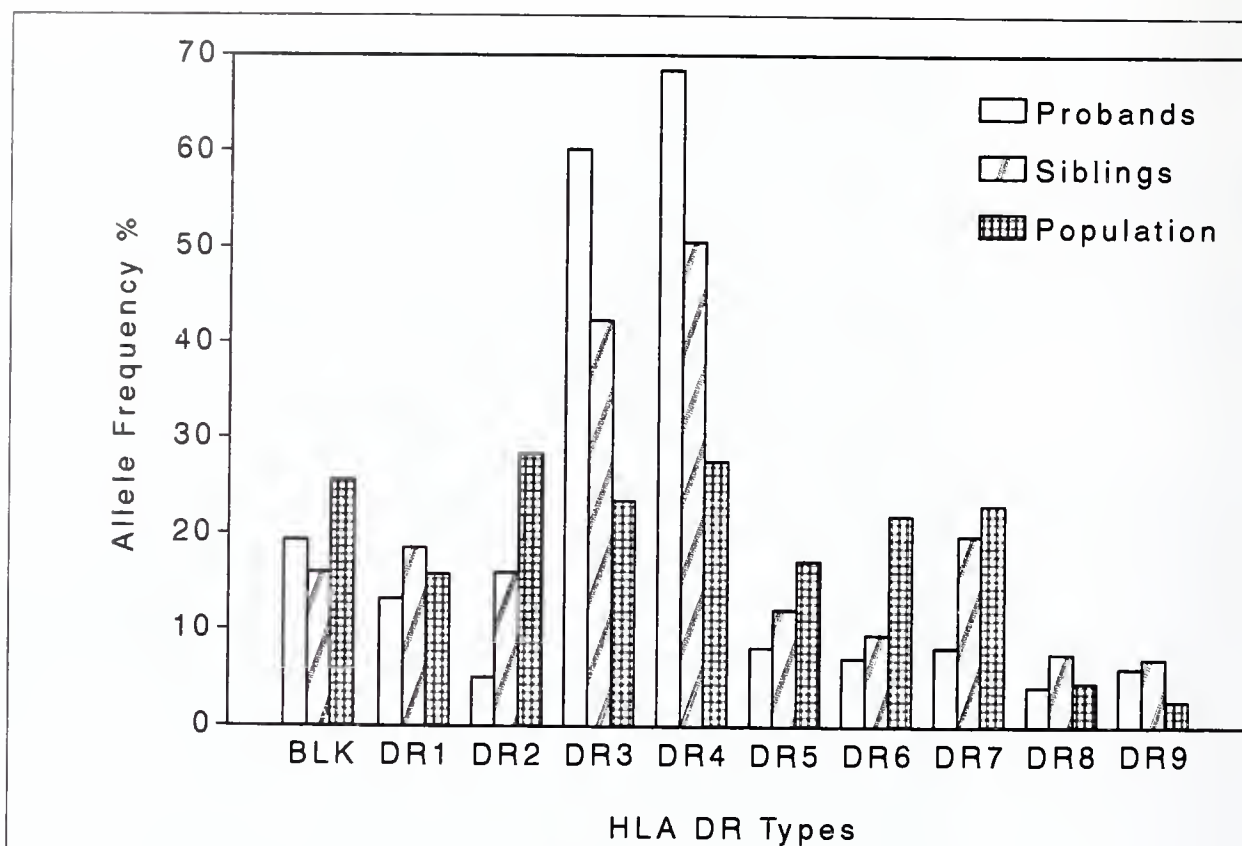


fig.1 Prevalence of Various DR Alleles in SE USA Population, Type I Diabetic Children and Non-Diabetic Siblings of Probands

## Results

A comparison of frequencies of DR alleles in type 1 diabetic children, their unaffected siblings and the at large population is illustrated in Fig 1. Since each individual possesses two #6 chromosomes, two alleles for each locus are generally expressed, thus the cumulative total for all haplotypes equals 200%. It can be readily appreciated that the DR3 and DR4 alleles are much more prevalent in IDDM (60.2%, 68.4% respectively) than in the general population (23.5%, 27.6%;  $p < 0.0001$ ) and that DR2 frequency is reduced (5.1% vs 28.5%;  $p < 0.0001$ ). Frequencies in siblings are generally intermediate between IDDM and population with both DR3 (42.3%) and DR4 (50.6%) significantly increased relative to the population ( $p < 0.0001$ ). The occurrence in the Southeast USA population of the diabetes-associated alleles DR3 and DR4 does not differ appreciably from other reported populations (26.3%-28.9% and 19.4%-32.3% respectively) nor is the frequency of the putative protective allele DR2 (28.5%) out of line with other populations (25.8%-35.4%). The preponderance of DR3 and DR4 in IDDM is comparable to the findings in other diabetic populations (48%-53.8% and 51.4%-72%

respectively).

Fig 2 illustrates the frequencies of DR allele pairings in the same groups. For simplification non-DR3, non-DR4 alleles are designated DRX. Population data are calculated assuming random pairings from individual allele frequencies while the IDDM and sibling data represent actually observed pairings.

Forty-six percent of IDDM children studied in the Louisville referral area possess both the DR3 and DR4 alleles. This is in contrast to only 6.5% calculated for the general population ( $p < 0.0001$ ). Only 7% of our IDDM children possess neither DR3 or DR4 with 93% possessing one or both of these diabetes associated alleles; 82.1% of non-diabetic siblings also possess one or both with 20.1% having both. The frequency of the DR3/DR4 compound heterozygous state in IDDM and in regional populations is comparable to that found in other areas.<sup>4</sup>

## Discussion and Conclusions

It is the general consensus that the major genetic predisposition to IDDM resides in genes of the MHC (HLA region) on chromosome #6. There

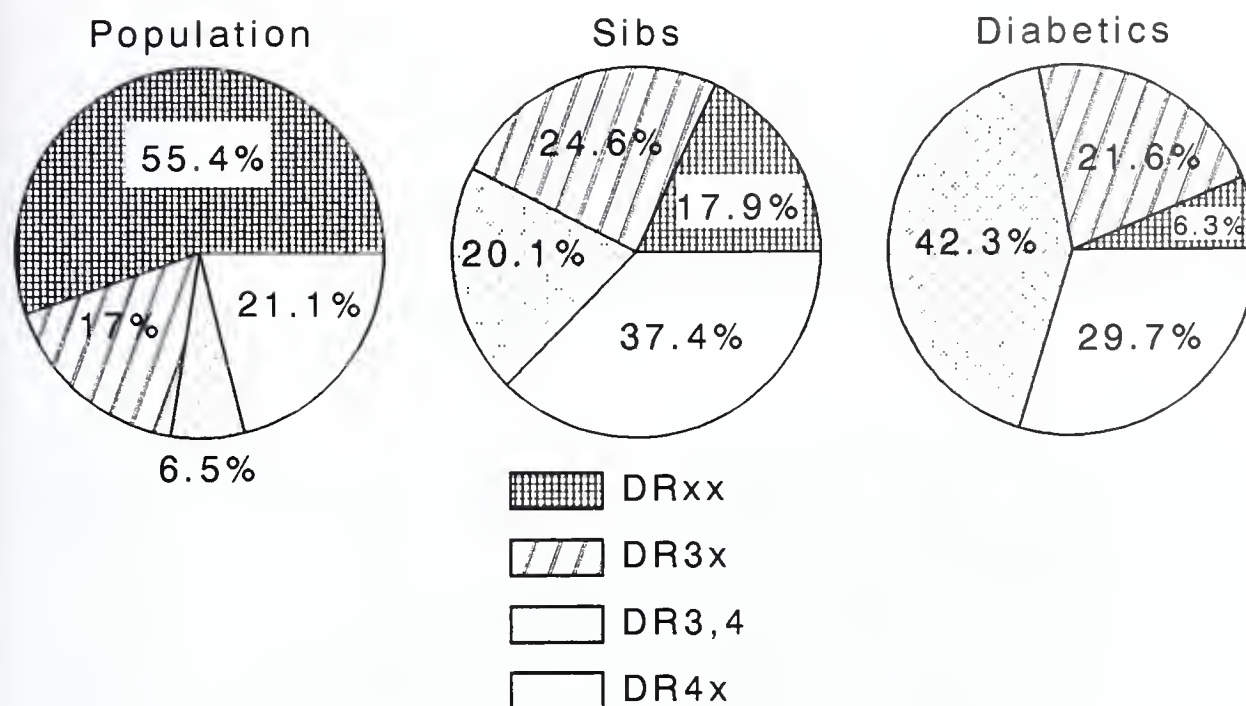


fig.2 Proportion of DRxx, DR3x, DR3,4, DR4x in Studied Groups

appear to be distinct genetic predispositions to islet cell damage by viral agents and to an autoimmune response to islet cell injury. DR4 is considered a marker for the viral susceptibility and DR3 for the autoimmune predisposition.<sup>5</sup> It is not surprising that these two factors seem to act in concert in almost half of children who develop IDDM with viral damage to islet cells presumably triggering an autoimmune response which perpetuates islet cell destruction. Generally accepted estimates of the relative risks for developing IDDM for individuals possessing DR3 (5-6 fold) or DR4 (3-4 fold) or both (20 fold)<sup>6,7</sup> would appear to apply to our region although actual calculation of risk would require the control sample to be drawn from the same geographic confines as the IDDM group.

Kentucky has been identified as an area with a prevalence rate for IDDM above the national average. No insight into the basis for this is afforded by these data. Observed frequencies of IDDM-associated DR alleles are not increased in the SE USA region but a more localized population study might be more informative. The slightly higher percentage of our IDDM children possess-

ing both DR3 and DR4 suggests a closer linkage of these alleles to actual diabetes genes but detailed DQ analyses will be necessary to illuminate this issue.

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# Pneumothorax: An Unusual Presentation of Primary Bronchogenic Neoplasm

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*We report the occurrence of spontaneous pneumothorax as the initial pulmonary event in a patient subsequently found to have a primary adenocarcinoma of the ipsilateral lung. A review of the literature regarding this rare presenting feature of bronchogenic neoplasm is provided.*

## Introduction

Spontaneous pneumothorax is a rare presenting feature (0.5%) of primary lung cancer.<sup>1,2</sup> There have been only 42 cases reported in the English language medical literature since the first association was published in 1955.<sup>3</sup> One of the proposed mechanisms by which a bronchogenic neoplasm may cause pneumothorax is cavitation involving the visceral pleura. Interestingly, adenocarcinoma histology has been reported in only 4% of cavitating lung neoplasms.<sup>4</sup> We report a patient who experienced both of these unusual

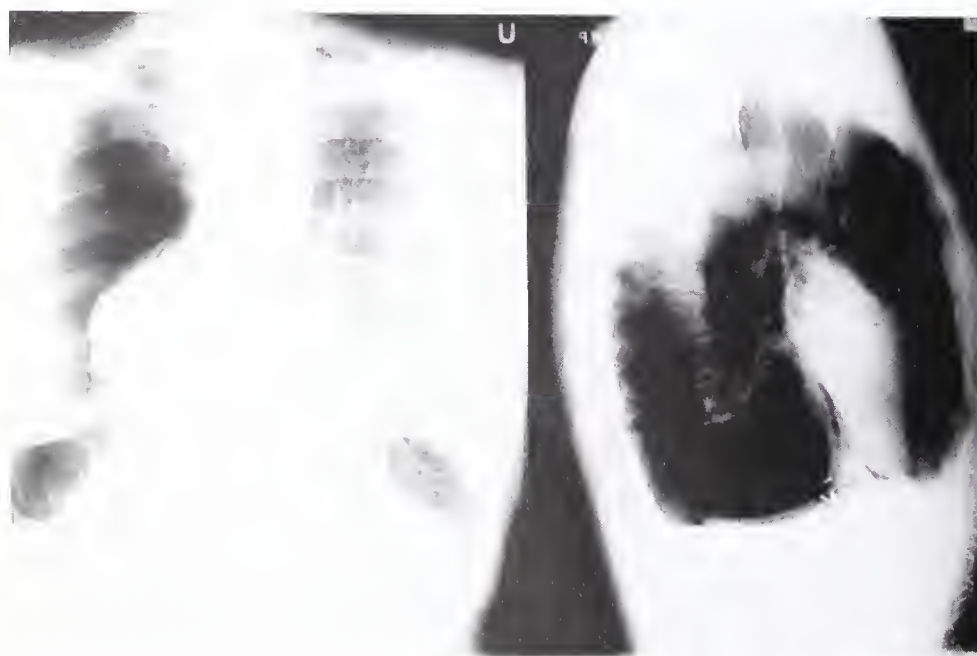
features of primary bronchogenic adenocarcinoma. We provide a current review of pneumothorax associated with primary lung cancer.

## Case Report

The patient, a 65-year-old male, presented to the hospital in respiratory distress complaining of a sudden onset of right-sided chest pain and dyspnea. He denied any trauma or chronic health problems; was taking no medications; had undergone gastric surgery for peptic ulcer disease 15 years earlier; and had smoked one pack of cigarettes daily for 46 years.

His blood pressure was stable, but his heart rate was 130 BPM. His breathing was shallow with a respiratory rate of 24/min. The remainder of his physical examination was normal except for a healed midline abdominal scar, the absence of breath sounds in the right hemithorax, and increased resonance of the right chest to direct percussion. Chest radiograph confirmed the presence of a 70% pneumothorax on the right side (Fig 1). Reexpansion of the right lung was accomplished by tube thoracostomy. He was discharged 2 weeks later after the chest tube had been removed and continued expansion of the lung was confirmed.

Six months later, the patient returned to the hospital, again complaining of right-sided chest pain. He was not in respiratory distress and denied dyspnea. He admitted to having a persistent cough of 5 months duration which occasionally produced small amounts of white sputum. He denied hemoptysis. The patient was afebrile and appeared well nourished. His vital signs were normal. A small healed scar was present in the right axilla from the earlier chest tube insertion. Breath sounds were present bilaterally, but were significantly decreased in the posterior aspect of the right mid-thorax. His physical examination was otherwise normal. Laboratory studies, including sputum examination, were normal.



**Fig 1** — Initial chest radiograph showing 70% pneumothorax on right side.

**Table 1.** Previously reported patients\* with primary bronchogenic neoplasm presenting with pneumothorax — categorized by cell type.

	Squamous cell	Adeno-carcinoma	Small cell	Large cell	Alveolar cell
Number of patients	26	7	2	6	1
Male/Female	23/3	6/1	1/1	6/0	1/0
Mean age in years	59	56	53	48	48
Number with delayed diagnosis	10	0	1	2	1
Number of patients <40 years old	0	1	0	4	0

\*Forty-two patients reported by 22 authors. References available on request.

The chest radiograph now showed consolidation in the superior segment of the right lower lobe. This density had the appearance of cavitation with a small air-fluid level. CT of the chest confirmed the presence of a cavitating lesion in the superior segment of the right lower lobe (Fig 2) and suggested the presence of mediastinal lymphadenopathy.

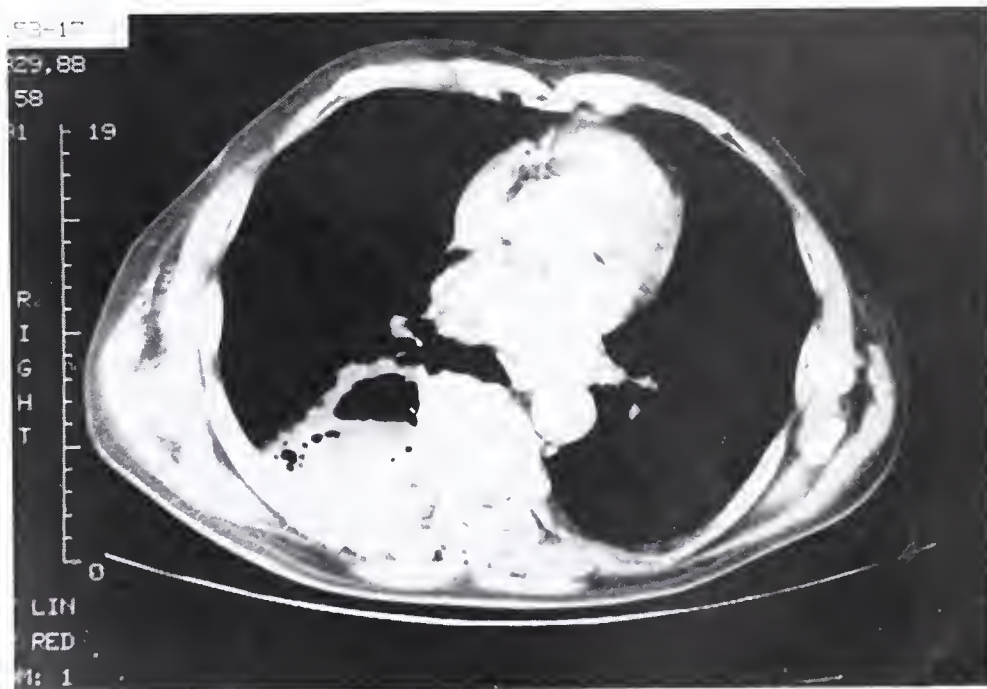
Brushings, biopsies, and bronchial washings were obtained from the superior segment by flexible fiberoptic bronchoscopy but failed to contain any microbial pathogens or malignant cells. Adenocarcinoma was subsequently diagnosed by a CT guided fine needle aspiration (Fig 3).

A preoperative metastatic work-up was negative. Mediastinoscopy was performed and the lymph nodes that were biopsied were free of tumor. The patient agreed to thoracotomy. The tumor, however, was determined intraoperatively to be unresectable because of extensive vascular involvement. The open lung biopsy confirmed the diagnosis of adenocarcinoma.

## Discussion

The first report of primary carcinoma of the lung presenting as pneumothorax was published in 1955 and involved two patients.<sup>3</sup> As in our case report, a delay in the diagnosis of the lung cancer occurred in both patients. In fact, of the 42 previously reported patients, one-third experienced a mean delay of 3.1 months before the diagnosis of neoplasm was made. In these cases, there was no suspicion of lung cancer on review of the reexpansion chest radiograph.

The demographics of the previously reported cases has been summarized in Table 1. As with all types of lung cancer, males predominate in the group of reported patients (88%). The mean age of patients with pneumothorax and bronchogenic carcinoma is 56 years, with a range of 31 years to 74 years. Five patients (12%) were under the age of 40 years, which is disturbing given the



**Fig 2** — CT scan of the chest performed 6 months later showing a cavitating lesion in the superior segment of the right lower lobe.



**Fig 3** — Adenocarcinoma in the CT guided fine needle aspirate of the lesion in the superior segment of the right lower lobe.



## Pneumothorax

relatively low incidence of bronchogenic carcinoma before this age.

Several mechanisms have been proposed to explain the occurrence of pneumothorax in the context of lung cancer. The first, and least likely, is the chance rupture of an emphysematous bleb independent of the presence of cancer. While this may occur, the relative decline in spontaneous pneumothoraces after adolescence has been well documented. In lieu of serendipity, distortion of lung architecture by the tumor mass may alter the torque on the lung parenchyma and lead to rupture of alveoli with pneumothorax.<sup>5</sup> The most direct cause of pneumothorax, however, is probably direct pleural involvement by a cavitating tumor.<sup>6</sup> All types of tumor histology have been seen in association with pneumothorax, but squamous cell histology has been most common. This is also the tumor type most prone to cavitate.

Cavitation of a primary bronchogenic carcinoma is considered by some investigators to correlate with a greater incidence of vascular invasion and metastasis. Thus, the likelihood of a poorer outcome is higher than for patients with nonnecrotic, noncavitary lung cancers.<sup>6</sup> This observation should be considered in the preoperative counseling and evaluation of these patients prior to thoracotomy.

The incidence of cavitation in bronchogenic neoplasm has been determined in two large studies to range from 12% to 15%.<sup>4,7</sup> Interestingly, the mean age of patients with cavitating lung cancer was 58 years — not significantly different from the mean age of lung cancer patients who experienced pneumothorax. In each large series, only 4% of cavitating tumors were adenocarcinomas.

Our patient with primary adenocarcinoma of the lung experienced cavitation which was easily

recognized radiographically 6 months after initial presentation. Retrospective review of the films taken at the time of his first admission were unremarkable. Nevertheless, it is a reasonable assumption that a focus of adenocarcinoma was present at that time which disturbed the pleura or parenchyma sufficiently to cause his pneumothorax.

In summary, the occurrence of a spontaneous pneumothorax in an adult smoker should alert the clinician to the possibility of an unsuspected pulmonary neoplasm. This is a relatively rare presentation for lung cancer, but should be ruled out by close scrutiny of the reexpansion chest films and continued follow up of high risk patients.<sup>8</sup>

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Faced with a Recommended Daily Dietary Allowance of 15 mg, the question is a good one for women aged 19-50. Iron is one of the nutrients most often lacking in the American diet. Low intakes of iron over prolonged time can lead to iron deficiency anemia.

In the 1986 USDA Continuing Survey of Food Intakes by Individuals<sup>1</sup>, women of child-bearing years reported a mean intake of 1588 calories a day. Since the American diet averages about 6-7 mg iron per 1000 calories, it's not surprising that the same survey found that most of these women are getting about 60 percent of their RDA for iron.

Yet consider, one three-ounce serving of lean sirloin contains 2.8 mg of iron, about forty to sixty percent of which is heme iron, the most bioavailable form. In addition, the presence of beef or other meats in a meal increase the bioavailability of nonheme iron from foods such as vegetables and grains.

Importantly, lean beef can also meet fat and cholesterol guidelines of most leading heart and health authorities. The how-to's are good advice for almost anyone.

Start with "The Skinniest Six" shown below. None is more than 180 calories per three-

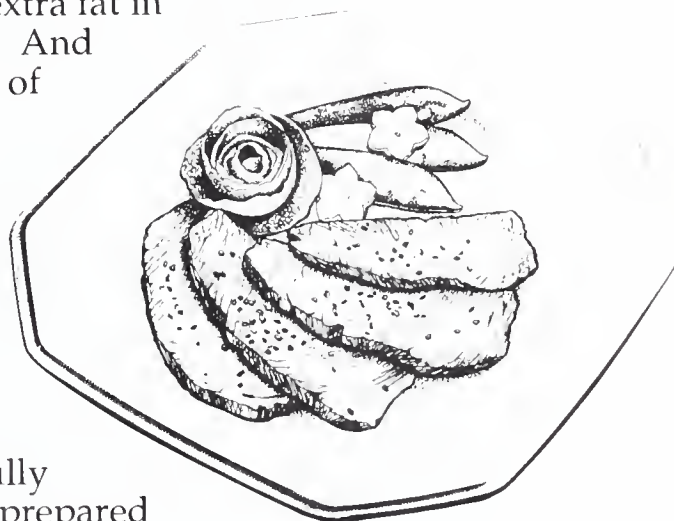
ounce cooked, trimmed serving. All are easy to specify at the meat counter.

These six cuts also simplify portion control. Four ounces uncooked equals about three ounces cooked. Grilling, broiling and roasting add no extra fat in cooking. And

the taste of beef makes it easy to dispense with fat-laden sauces.

Carefully chosen, prepared and served, "The Skinniest Six" provide an impressive list of essential nutrients for under 180 calories per three-ounce serving.

And as part of a specific plan to increase dietary iron, in a balanced diet, beef can be one of the best-tasting recommendations you'll ever make.



**BEEF**



## "The Skinniest Six"\*



**Eye of Round**

1.65 mg iron  
155 calories  
5.5 g total fat  
(2.1 g saturated fat)  
59 mg cholesterol



**Round Tip**

2.50 mg iron  
162 calories  
6.4 g total fat  
(2.3 g saturated fat)  
69 mg cholesterol



**Top Loin**

2.10 mg iron  
172 calories  
7.6 g total fat  
(3.0 g saturated fat)  
65 mg cholesterol



**Top Round**

2.45 mg iron  
162 calories  
5.3 g total fat  
(1.8 g saturated fat)  
72 mg cholesterol



**Sirloin**

2.85 mg iron  
177 calories  
7.4 g total fat  
(3.0 g saturated fat)  
76 mg cholesterol



**Tenderloin**

3.05 mg iron  
174 calories  
7.9 g total fat  
(3.1 g saturated fat)  
72 mg cholesterol

*Uncooked whole cuts are shown for purpose of identification.*

## Composite of cooked retail cuts of beef\*

Protein	25.9 g
Iron	2.7 mg
Zinc	6.0 mg
Vitamin B-12	2.28 mcg
Thiamin	.08 mg
Niacin	3.6 mg
Sodium	55 mg
Total Fat	8.7 mg
(Saturated Fat)	(3.4 g)
Cholesterol	76 mg
Calories	189

<sup>1</sup> United States Department of Agriculture, "Nationwide Food Consumption Survey, Continuing Survey of Food Intakes by Individuals (NFCS, CSFII)" Report No. 86-1.

\* Nutrients in 3 oz. trimmed and cooked. USDA Handbook 8-13, Rev 1986



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## “DOLE-DRUMS” (with apologies to *Webster's Dictionary*)

**W**ebster's dictionary defines the doldrums as “dullness; gloomy feeling; low spirits.” How many of us have the winter doldrums? Some try to get rid of this “gloomy feeling” by heading to warmer places such as Hawaii where “dole” means pineapple and “drums” means beach parties.

There is a better and less expensive way to confront the doldrums of winter. **Get involved!** Get involved with the Auxiliary. Support and get actively involved at the county, state and national levels. These organizations have many worthwhile activities both in service and recreation.

Even if you are involved in other organizations (which do great work for the communities), please join **OUR** auxiliaries. We need your financial support.

All these good deeds during this cold January can do nothing but make one feel better and warmer inside. By getting involved in these kinds of efforts, we, as doctor's spouses, will “Improve the Image of Medicine.”

**Betty Schrod**  
**AKMA President**

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**“Get involved with the  
Auxiliary”**

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# *The Medical Entrepreneur's Handbook: A Physician's Guide to Income Producing Medical Ventures.*

Harvey E. Knoernschild, MD

CE/Q Publishers, Inc  
PO Box 50399  
Palo Alto, CA 94303  
\$24.00

This interesting and informative book is the synthesis of a number of authors' experiences in the business world of medicine. As an introduction, Dr Knoernschild is the seer of future medicine. He sees a "restructuring" and in this maelstrom the medical entrepreneur has the chance to profit by the falling chips. His coauthors represent heroes in this new world, having proven themselves dexterous and pioneering in an innovative way. That economic pressures are the fuel is never denied. In fact, no apology is forthcoming for the profiteering that is and will be possible. Dr Knoernschild is convinced that things will happen, regardless of our participation. Why not run with the ball!!

Dr Alan Pierrot is a successful owner and manager of surgical facilities. From this perspective, he describes how cost effective can cohabitate with quality. Physician ownership does not imply some conspiracy, but rather some educated guidance for the development of

future facilities. Dangers and warnings must be recognized and other authors (Alan Bickel, MD, Alex Fraser, MD) are somewhat less strident about embarking on this type of project. Even postoperative care in a "Recovery Care Center" is grist for adventure into possible business and enterprise.

"Urgicenter" may be a neologism for non-hospital emergency rooms, but Dr Mark Congress conceived and developed such service and became successful with personalized care!! A similar experience with an Occupational Medical Clinic gave other authors (Lester Sacks, MD, Claire Carpenter Sacks, BS) a chance to work in a hospital or independent facility.

Presently, imaging centers, including mammography and breast cancer specialties, are dotting the community. Advice about such ventures is fairly presented by Drs David Kramer and Cesar Mayo. Further distancing from hospital hegemony can be accomplished

through prototype acute home care projects and even an "InfusiCenter Clinic."

Multispeciality organizations have models in Kaiser, Mayo Clinic, Cleveland Clinic, etc, but for the management competent physician, opportunity beckons now for further local developments. Dr Peter Crandall suggests that such associations can insulate us from the intrusions of liability, government, and insurance. He, like other authors (Marvin Rawitch, MD, William Sueksdorf, MD, and Paul Schrupp, BA), suggest that such alliances would be formidable, and capable of rapidly accommodating.

Both a bibliography and other readings are suggested to the interested reader. To the physicians of the 90s and the 21st century, such information is both intriguing and perhaps humbling.

**Stephen Z. Smith, MD**



# AIM HIGH



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## Thoughts on Paperwork The Use of Your Signature

**T**O THE EDITOR: Many of you saw the *Paducah Sun* article of July 22, 1990, on the subject of the sale of orthotic devices to nursing homes. For those of you who did not, the article may be summarized as follows:

Large numbers of "custom" prosthetic devices — elbow and ankle splints to protect heels and elbows of aged nursing home patients were sold to several nursing homes in Kentucky. These were dispersed to patients at a cost to Medicare of from \$400 - \$600 per individual. (Cost must have been about \$20.)

Such devices may not legally be given to patients without a Certificate of Medical Necessity or prescription signed by an MD. Some had no such signature. Many did. A number of physicians when contacted about their signatures told tales of being overburdened by paperwork, of not knowing what they signed, of not knowing the cost, and many other similar excuses.

This abusive and fraudulent scheme is being uncovered across this state, in Tennessee, and in Mississippi.

The Federal government has spent easily over one million of your and my tax dollars.

Those instances without a Certificate signed by a physician can be prosecuted as fraud.

Those cases with signed script by physicians in most instances make the profession insensitive, abusive of the Medicare system, subject to remarks of collusion with the sales company, and worse.

A case might be made against some physicians for poor care or even negligence. The Medicare bureaucracy has every right to develop a poor opinion of our profession. We can

only expect more paper work, harsher threats, and even civil or criminal prosecution when we act so unwisely.

We are given enormous privileges and trust by our patients and our government. Despite what any physician says about Medicare, billions have been given to us every year as fees for services rendered since the inception of the program. These billions have increased at a steady and ascending rate. There is no physician in this country who is not better off as a result.

When we turn aside our responsibilities, no matter how seemingly trivial, no matter how "routine" and "unimportant," no matter how irksome, we also abdicate certain rights. There are many who stand ready to grasp those rights, circumscribe us beyond our wildest imagination, and really reduce us to lackeys.

Think about it. Be warned — be careful what you sign or stamp.

**J. B. Holloway, MD**

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Dr Holloway is a Past President of KMA and former general and thoracic surgeon. He currently serves as Medical Director for Medicare Part B in Kentucky.

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theophylline resulting in elevation of serum theophylline levels into the toxic range. Seizures with permanent severe brain damage may occur as a result of high serum theophylline levels. Please have your members who use this drug review the medical literature regarding the safe use of theophylline. Consider using other medications first before using theophylline. If theophylline is used, keep serum levels between 5-15 ug/ml instead of the 10-20 ug/ml range, and should fever or viral infections of 24 hours duration or longer occur reduce the dose of theophylline by one-half during that illness, or if that is not safe then monitor theophylline levels more carefully.

**James A. Klicpera, MD**  
The Everett Clinic  
3901 Hoyt Ave  
Everett, WA 98201

## References

- Koren G, Greenwald M. Decreased theophylline clearance causing toxicity in children during viral epidemics. *Journal of Asthma* 1985;22(2):75.
- Kraemer MJ, et al. Altered theophylline clearance during an influenza B outbreak. *Pediatrics*. 1982;69:476.
- Weinberger M. Theophylline toxicity and viral infections. *Pediatrics*. 1982;70:508.
- Weinberger M. *Managing Asthma*. Baltimore: Williams & Wilkins; 1990.

## Theophylline Toxicity

**T**O THE EDITOR: Theophylline toxicity resulting from overdose has been recognized for a long time as a potential problem when using this drug in the management of reactive airways disease. It is now recognized that elevated temperature lasting 24 hours or longer and probably many viral infections can significantly alter the clearance of



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**Action:** Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

**Indications:** Yocon<sup>®</sup> is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

**Contraindications:** Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

**Warning:** Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

**Adverse Reactions:** Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.<sup>1,2</sup> Also dizziness, headache, skin flushing reported when used orally.<sup>1,3</sup>

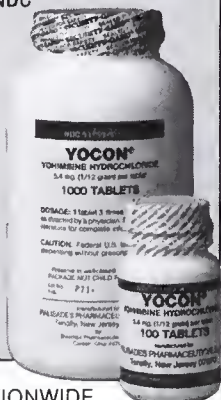
**Dosage and Administration:** Experimental dosage reported in treatment of erectile impotence.<sup>1,3,4</sup> 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.<sup>3</sup>

**How Supplied:** Oral tablets of Yocon<sup>®</sup> 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

### References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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**Preparation** — Manuscripts should be typewritten in double spacing throughout, including references, tables, legends, quotations, and acknowledgments. Submit the original and one copy, retaining a copy for proofreading. Ordinarily articles should not exceed 3,000 words in length. Titles should include the words most suitable for indexing the article, should stress the main point, and should be short. A synopsis-abstract must accompany each manuscript. The synopsis should be a factual (not descriptive) summary of the work and should state the problem considered, methods, results and conclusions.

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## FEBRUARY

**24-March 1 — 22nd Family Medicine Review, Session I;** Hyatt Regency Hotel, Lexington, KY. Contact: Ms Joy Greene, Director CME, 132 College of Medicine Office Bldg, U of K, Lexington, KY 40503-0086; 606/233-5161.

**28-March 2 — Advances in Pulmonary and Critical Care Medicine,** Round Hill Resort, Montego Bay, Jamaica. Contact: LaDonna Nail, Southern Medical Association, 35 Lakeshore Dr, Birmingham, AL 35219-0088; 1/800/423-4992; 205/945-1840.

**28-March 2 — Innovations in Radiological Techniques and Technologies,** The Princess Hotel, Acapulco, MX; Contact: LaDonna Nail, Southern Medical Association, 35 Lakeshore Dr, Birmingham, AL 35219-0088; 1/800/423-4992; 205/945-1840.

## MARCH

**13-15 — Seventeenth International Symposium on Psychopharmacology,** Holiday Inn-Hurstbourne, Louisville, KY. Contact: Laura Tucker, CME, University of Louisville, Louisville, KY 40292; 502/588-5329.

**15-17 — Office Management of Infectious Diseases,** Sandestin Beach Hilton, Destin, FL. Contact: LaDonna Nail, Southern Medical Association, 35 Lakeshore Dr, Birmingham, AL 35219-0088; 1/800/423-4992; 205/945-1840.

**25 — Dean's Hour — W. O. Johnson Lecture,** University of Louisville Health Sciences Center Auditorium, Louisville, KY. Contact: Laura Tucker, CME, University of Louisville, Louisville, KY 40292; 502/588-5329.

## APRIL

**4-5 — Operative Gynecologic Endoscopy,** University of Louisville Health Sciences Center Instructional Bldg, Louisville, KY. Contact: Laura Tucker, CME, University of Louisville, Louisville, KY 40292; 502/588-5329.

**12-13 — General Endocrine Review;** Hyatt Regency Hotel, Lexington, KY. Contact: Ms Joy Greene, Director CME, 132 College of Medicine Office Bldg, U of K, Lexington, KY 40503-0086; 606/233-5161.

**14-17 — 59th Annual Assembly, Southeastern Surgical Congress;** Hotel Intercontinental, New Orleans, LA. Contact: Roger Sherman, MD, 69 Butler St, SE, Suite 314, Atlanta, GA; 404/221-0570.

**14-25 — 32nd Annual Postgraduate Institute for Pathologists in Clinical Cytopathology,** In-Residence Course B, Johns Hopkins University School of Medicine, Baltimore, MD. Contact: John K. Frost, MD, or Betty Ann Remley, 111 Pathology Bldg, The Johns Hopkins Hospital, Baltimore, MD 21205, 301/955-8594.

**19-21 — Focus on the Athletic Patient,** The Cottages, Hilton Head, SC. Contact: LaDonna Nail, Southern Medical Association, 35 Lakeshore Dr, Birmingham, AL 35219-0088; 1/800-423-4992; 205/945-1840.

**19-21 — Advances in Surgical Techniques and Technologies,** The Homestead, Hot Springs, VA. Contact: LaDonna Nail, Southern Medical Association, 35 Lakeshore Dr, Birmingham, AL 35219-0088; 1/800/423-4992; 205/945-1840.

**19-21 — Sports Medicine for Physicians;** Hyatt Regency Hotel, Lexington, KY. Contact: Ms Joy Greene, Director CME, 132 College of Medicine Office Bldg, U of K, Lexington, KY 40503-0086; 606/233-5161.

**25-27 — High Risk Pregnancy Postgraduate Course,** Hyatt Regency Hotel, Louisville, KY. Contact: Laura Tucker, CME, University of Louisville, Louisville, KY 40292; 502/588-5329.

**26-28 — Diagnostic Dilemmas in Cardiology,** Kingston Plantation, Myrtle Beach, SC. Contact: LaDonna Nail, Southern Medical Association, 35 Lakeshore Dr, Birmingham, AL 35219-0088; 1/800/423-4992; 205/945-1840.

**26-27 — Contemporary Pediatrics for the Practicing Physician;** Hyatt Regency Hotel, Lexington, KY. Contact: Ms Joy Greene, Director CME, 132 College of Medicine Office Bldg, U of K, Lexington, KY 40503-0086; 606/233-5161.

## MAY

**3-5 — Diagnostic Dilemmas in Neurology and Psychiatry,** The Grand Hotel, Point Clear, AL. Contact: LaDonna Nail, Southern Medical Association, 35 Lakeshore Dr, Birmingham, AL 35219-0088; 1/800/423-4992; 205/945-1840.

**16-19 — Focus on the Female Patient,** Bay Point Resort, FL. Contact: LaDonna Nail, Southern Medical Association, 35 Lakeshore Dr, Birmingham, AL 35219-0088; 1/800/423-4992; 205/945-1840.

**17-18 — Annual Meeting, The Virginia Society of Otolaryngology-HNS,** Omni Waterside Hotel, Norfolk, VA. Contact: Donna Scott, 4205 Dover Rd, Richmond, VA 23221, 804/353-2721.

**18 — Nephrology Seminar,** University of Louisville Health Sciences Center Auditorium, Louisville, KY. Contact: Laura Tucker, CME, University of Louisville, Louisville, KY 40292; 502/588-5329.

**19-24 — Twenty-Second Family Medicine Review — Session II;** Hyatt Regency Hotel, Lexington, KY. Contact: Ms Joy Greene, Director CME, 132 College of Medicine Office Bldg, U of K, Lexington, KY 40503-0086; 606/233-5161.

## JUNE

**9-13 — Fifteenth Symposium on Lung Disease,** The Cloister, Sea Island, GA. Contact: LaDonna Nail, Southern Medical Association, 35 Lakeshore Dr, Birmingham, AL 35219-0088; 1/800/423-4992; 205/945-1840.

**17-21 — Thirteenth Family Medicine Review,** Hyatt Regency Hotel, Louisville, KY. Contact: Laura Tucker, CME, University of Louisville, Louisville, KY 40292; 502/588-5329.



# KMA Hospital Medical Staff Section Holds Annual Meeting



The KMA Hospital Medical Staff Section (HMSS) held its Sixth Annual Meeting at the KMA Headquarters Office in Louisville on August 30, 1990. KMA President Nelson B. Rue, Jr, MD, Bowling Green, welcomed participants to the meeting and spoke of the importance of the KMA-HMSS as it provides an avenue for discussion of mutual problems of the hospitals and medical staffs. He emphasized the need for medical staffs to have properly executed bylaws and to know what they contain.

Charles J. Cronan, IV, KMA Legal Counsel from the firm of Stites & Harbison in Louisville, discussed several new state laws, including the Health Care Surrogate Act and the

Living Will, and explained the role of the physician in treating patients who have executed a living will or who have designated a health care surrogate. He emphasized that hospitals and physicians need to have guidelines in place for dealing with these matters. Mr Cronan spoke briefly about the Patient Anti-dumping Law, noting that it contains stringent restrictions on the transfer of emergency patients. He also discussed the importance of medical staff bylaws and team players who provide quality care.

Wally O. Montgomery, MD, Paducah, Chairman of KMA's Committee on State Legislative Activities, used a slide presentation he

had created to discuss KMA's legislative agenda during the 1990 Kentucky General Assembly. He noted that during the Session, 1825 bills and resolutions were introduced, 295 of which were medically related. KMA was successful in getting 24 bills passed into law. Dr Montgomery discussed the passage of HB 553, which protects qualified retirement plans from judgment in the event of bankruptcy. He also stressed the importance of HB 781 and SB 236, both bills passed by the 1990 KGA to address abuses to the utilization review concept and provide protection to patients and providers from claims review agents representing peer review organizations. Other successful

legislation during the Session included AIDS, living will, and medical care for the indigent.

Jeffrey Rice, MD, Medical Director for Sentinel Medical Review Organization, noted that Sentinel is physician directed and performs whatever functions are needed to see that services delivered under Medicare reflect proper utilization and quality of care. Dr Rice noted that although 10,000 cases were backlogged when Sentinel became the PRO for Kentucky, Sentinel is now current in its revision. He also encouraged physician participation as reviewers for Sentinel. Dr Rice then responded to individual questions from the audience.

Marva Gay-Callahan, Staff Legal Counsel for the Kentucky Hospital Association, spoke about the Emergency Medical Treatment Act (part of COBRA) passed by Congress. The law mandates how to treat emergencies and patients in labor as it specifies that any person coming to the hospital for treatment must be examined, and emergencies must be stabilized. It also prevents "patient dumping" from one facility to another. Because of the ambiguous portions of this Act, Ms Gay-Callahan stressed the importance of thorough documentation in the patient's records. She noted that until regulations are released in 1991 and until court rulings have clarified the ambiguous portions of this Act, hospitals and physicians must be particularly wary of actions that could trigger investigations and enforcement actions.

Sharon Swan, Program Administrator for the AMA Department of Hospital Medical Services, spoke about the Health Care Quality Improvement Act of 1986, noting it has two primary purposes — to



**1990-91 HMSS Steering Committee (left to right) William O'Bryan, MD; Harold L. Bushey, MD; Rex Cox, MD; Donald J. Swikert, MD, Chairman. Earl P. Oliver, MD; David Watkins, MD; and Robert Emslie, MD, were unavailable for photo.**



**1990-91 HMSS Nominating Committee (left to right) H. Michael Oghia, MD; Steve S. Kraman, MD; Ken Green, MD; James T. Ramsey, MD. John J. Buchino, MD, Chairman, was unavailable for photo.**





**Nelson B. Rue, Jr, MD, KMA President, 1989-90**



**Wally O. Montgomery, MD, Chairman, KMA Committee on State Legislative Activities**



**Charles J. Cronan, IV, KMA Legal Counsel**



**Marva Gay-Callahan, Staff Legal Counsel, Kentucky Hospital Association**



**Sharon Swan, Program Administrator, AMA Department of Hospital Medical Staff Services**

is required to inform physicians of any report filed against them, and queries can be made to the data bank by hospitals, state licensing boards, and health care entities that have a formal peer review process. In general, lawyers do not have access to information in the data bank unless a hospital neglected to query the data bank about the practitioner in question.

Ms Swan noted that AMA has been very active, on behalf of physicians, and has had representation on several committees involved with the operation of the data bank.

Marva Gay-Callahan noted that the same data bank rules that apply to licensed practitioners also apply to certified practitioners. In addition, there is no limitation on the length of time information will be kept in the data bank.

During the business meeting, Donald J. Swikert, MD, Chairman, emphasized that both the KMA and AMA Hospital Medical Staff Sections are available to individual medical staffs should specific questions or problems arise or resource material be needed. He reviewed several problem areas that have arisen during the past year where the KMA-HMSS has been able to provide assistance.

Elections were held for three positions on the Steering Committee. Rex Cox, MD, Louisville, was elected Secretary, and elected to the two member-at-large positions were Robert Emslie, MD, Madisonville, and William O'Bryan, MD, Owensboro. In addition to Dr Swikert, other members of the Steering Committee are Earl P. Oliver, MD, Scottsville, Vice Chairman; David R. Watkins, MD, Louisville, Delegate; and Harold L. Bushey, MD, Alternate Delegate.

Elected to the 1990-91 Nominating Committee were John J. Buchino, MD, Louisville, Chairman; Ken Green, MD, Leitchfield; Steve S. Kraman, MD, Lexington; H. Michael Oghia, MD, Columbia; and James T. Ramsey, MD, Frankfort.

encourage physicians to engage in effective professional review by providing federal and state immunity for good faith peer review actions and to restrict the ability of incompetent physicians to move from state to state without having their incompetence discovered. The National Practitioner Data Bank, which opened on September 1, 1990, requires reporting of adverse actions on clinical privileges, medical malpractice payments, actions taken by state boards of medical examiners, and professional society membership actions. Ms Swan noted the data bank



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**PEOPLE**

**C. Dale Brown, MD**, Paducah, and **James C. King, Jr, MD**, Hopkinsville, were named as Fellows of the American College of Radiology during ceremonies at the ACR annual meeting held recently in Nashville, TN. Selected for their outstanding contributions to the field of radiology, these KMA members were among 131 new fellows named by the College's Board of Chancellors.

**Robert S. Howard, II, MD**, a second-year resident at the University of Kentucky, was among 40 physicians selected to participate in a pilot program, "Introduction to Research," at the Radiological Society of North America Scientific Assembly and Annual Meeting. Institutions across North America were offered the opportunity to nominate one second-year radiology resident to participate in the program, and each institution whose candidate was selected received a grant to be used to help advance the participant's academic career.

Three of KMA's members recently received 3-year appointments as the Cancer Liaison Physician for the Cancer Program at a hospital in their area. They are **J. Ronald Staten, MD**, Our Lady of Bellefonte Hospital, Ashland; **Justin MacCarthy, MD**, T. J. Samson Community Hospital, Glasgow; and **James C. Dowdy, MD**, Murray Calloway County Hospital, Murray. These members are among a national network of 2,300 volunteer Cancer Liaison Physicians who provide leadership and support to the Hospital Cancer Program, and other Commission on Cancer activities of the American College of Surgeons.

Louisville orthopedists **Richard Holt, MD**, and **David Seligson, MD**,

recently spoke at the Puerto Rican Medical Association convention in Dorado, Puerto Rico. Dr Holt spoke on the treatment of spine problems and Dr Seligson spoke on the treatment of fractures.

**Larry Hattell, MD**, was recently appointed an assistant professor of medicine at the U of L School of Medicine.

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**UPDATES**
**Congressman Natcher  
Receives AMA Award**

Kentucky's Congressman William H. Natcher (D) was included in the group when the American Medical Association recently announced eight winners of its 1990 Nathan Davis Awards for contributions by public officials to advancing US health care.

The awards recognize major achievements in "the art and science of medicine and the betterment of public health" by elected and career public officials in national, state, and local governments. Congressman Natcher was recognized for his contributions in the fight against disease, disability, and premature death.

The awards are named for Nathan Davis, MD, AMA founder and first editor of its *Journal of the American Medical Association (JAMA)*. The first awards were presented in 1989.

**U of L added to bone marrow donor  
network**

Cancer patients who require lots of radiation or chemotherapy often need a bone marrow transplant as well.

"We know that the higher the dose of cancer therapy we give, the more likely that a response will be attained and cancer cells will be killed," said **Dr Roger Herzig**, Cancer Center director.

U of L can now help patients hook up with bone marrow donors because The James Graham Brown Cancer Center was recently added to the National Marrow Donor Program.

While 30% of patients find a suitable match from siblings or self-donation, the rest now have hope of finding unrelated donors with their blood types through the computer network. Call 1/800/234-BMTX to learn more about the donor program.

**New technique may improve heart  
attack survival rates**

Each year more than 400,000 are victims of sudden cardiac death.

According to U of L's **Igor Singer, MD**, director of electrophysiology at the School of Medicine, it's possible to reduce this death rate considerably. Singer and colleague **Joel Kupersmith, MD**, have joined six other medical centers across the United States in a 3-year study of a new defibrillator called a Cabbage Patch.

Dr Singer is an associate professor of medicine and Dr Kupersmith is chief of the cardiovascular division of the School of Medicine.

According to Dr Singer, the use of the Cabbage Patch defibrillator as a preventive measure in cardiac patients will improve survival rates from sudden cardiac death.

The Cabbage Patch, so named for the first letters of Coronary Artery Bypass, is an electrical device that is implanted as a preventive measure before the patient has a heart attack.

The study involving the defibrillator is correctly called CABG (pronounced but not spelled "cabbage") PATCH, for coronary artery bypass graft.



### Laser destroys cancer cells, leaving healthy tissue

Cancer researcher **T. Jeffery Wieman, MD**, is using a fiberoptic laser and a new drug to bring a ray of hope to cancer patients. The drug, Photofrin II, is strangely attracted to cancer cells. Why and how the drug is attracted to cancer is what Dr Wieman and his team of researchers are studying, reports the University of Louisville.

"We are the only lab in the world doing our particular work in this field," the Department of Surgery researcher said. "We hope to help as many people as we can." The patients suffer from various forms of cancer: recurrent skin or breast cancer, cancers of the lung, esophagus, mouth, throat, and many tumorous cancers inside the body.

### Dr McClave says even heavy people can be malnourished

With the use of his metabolic cart, **Stephen McClave, MD**, University of Louisville, is measuring the way patients use oxygen and carbon dioxide to estimate the number of resting calories they need each day. The gastroenterologist needs this information to make sure his critically ill patients aren't starving to death. People on the mend from a major illness or injury must not be underfed or they will starve. They must also not be overfed because fat adds stress to organs already in peril, he said.

For 20 years, doctors have fed critically ill patients by vein, but studies now show that this method can actually increase the stress on their system compared to feeding by tubes into the gut, Dr McClave said.

The stomach and intestines, or gut, is the first line of the body's immune system, or defense against bacteria. Alternative feeding through a vein causes the gut to relax its defense and allow bacteria into other

parts of the body oftentimes through the circulatory system. According to Dr McClave this can cause added infection, organ failure or stress.

Protein makes up most of the body including enzymes and white blood cells needed to fight infection. If protein is not supplied, energy needs are met by taking protein directly from the body. When this happens, the gut wall thins, heart muscles deteriorate and skeletal muscle disappears. Feeding by tubes into the gut, instead of by vein, may avoid this.

"You almost get the impression that the body is melting away as it strives to meet its own calorie and protein needs," Dr McClave said. "Hopefully, with the metabolic cart, we help keep malnutrition from being a factor in their illness."

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## NEW MEMBERS

Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.

### Bell

**Gautami S. Dholakia, MD** — PD  
12 Twin Acres, Middlesboro 40965  
1975, Seth G.S. Medical College, India

### Boyd

**Stephen D. Deitch, MD** — N  
2301 Lexington Ave, #310, Ashland 41101  
1985, Indiana U

### Boyle

**Richard J. Hempel, MD** — FP  
212 S 2nd St, Danville 40422  
1985, Vanderbilt U

### Christian

**Manoj H. Majmudar, MD** — PUD  
1725 Kenton St, Hopkinsville 42240  
1981, NHL Municipal Medical College, India

### Clark

**Rondal E. Goble, MD** — FP  
31 Casa Landa Way, Winchester 40391  
1987, Marshall U

### Daviess

**Nazih H. Salam, MD** — TS  
922 Triplett St, #5, Owensboro 42301  
1968, American U of Beirut

### Fayette

**J. Thomas Adkins, MD** — OBG  
2328 Woodfield Cir, Lexington 40515  
1986, Baylor

**William G. Boliek, MD** — C  
1800 S Limestone, #401, Lexington 40503  
1978, Tulane U

**Brian L. Brown, MD** — FP  
2087 Norborne Dr, Lexington 40502  
1987, U of Louisville

**Robert J. Fallis, MD** — N  
1221 S Broadway, Lexington 40504  
1979, U of Kentucky

**Nicholas J. Lynn, MD** — PD  
5396 Versailles Rd, Lexington 40510  
1984, Ohio State U, Columbus

**Gregory L. Robbins, MD** — IM  
3312 Ft Harrods Ct, Lexington 40513  
1984, U of Kentucky

**Thomas N. Zweng, MD** — S  
2384 Abbeywood Rd, Lexington 40515  
1984, U of California, LA

### Henderson

**John D. Smith, MD** — C  
1015 N Elm St, Henderson 42420  
1983, Robert Wood Johnson Med Sch, NJ

### Hardin

**George H. P. Flores, MD** — OBG  
884 Martin Ln, Radcliff 40160  
1964, St Louis U

**Cynthia A. Molloy, MD** — PD  
110 Amanda Ct, Radcliff 40160  
1983, U of Cincinnati

### McCracken

**Kevin D. Heath, MD** — GE  
612 Whitney, Paducah 42001  
1985, U of Arkansas

**Nelson**

**Ralph G. Ellis, Jr, MD** — AN  
112 Stonehouse Tr, Bardstown 40004  
1955, Med U of South Carolina

**Northern KY**

**Kerrin Burte, MD** — RHU  
455 Delta Ave, Cincinnati 45226  
U of Cincinnati

**Alan I. Cohen, MD** — IM  
2344 Crimson Ln, #10,  
Crescent Springs 41017  
1976, Tufts U

**Frederick Gensler, MD** — P  
106 Wellington Pl, Cincinnati 45219  
1970, State U of NY at Buffalo

**Richard M. Hoblitzell, MD** — ORS  
7570 US Hwy 42, Florence 41042  
1985, U of Cincinnati

**Richard C. Levy, MD** — EM  
234 Goodman St, Cincinnati 45267  
1972, U of Louisville

**Marc J. Starer, MD** — PD  
70 Fox Chase Dr, #12, Southgate 41071  
1986, Tulane U

**Philip Williams, MD** — IM  
525 Alexandria Pk, Southgate 41071  
1984, U of Cincinnati

**Taylor**

**Mark A. Henry, MD** — OPH  
500 Forest Hills Dr, Campbellsville  
42718  
1986, U of Kentucky

**Warren**

**James W. Johnson, Jr, MD** — TS  
1461 Mt Ayr Cir, Bowling Green 42103  
1977, U of Tennessee

**Richard D. Larson, MD** — FP  
1133 Adams St, Bowling Green 42102  
1974, U of Minnesota

**J. Scott Littleton, MD** — P  
250 Mooreborough Ln, Bowling Green  
42103  
1985, U of Louisville

**New In-Training****Fayette**

**Van S. Breeding, MD** — FP  
**Michael W. Eden, MD** — FP  
**James G. Huffman, MD** — OPH

**Kurtis Martin, MD** — S  
**Anthony T. Noble, MD** — FP  
**Larry E. Puls, MD** — OBG

**Jefferson**

**Robert O. Mitchell, MD** — S

**Northern KY**

**Vincent P. Tanamachi, MD** — FP

**DEATHS**

**Samuel M. Wigser, MD**  
**Cincinnati, OH**  
**1933-1990**

Samuel M. Wigser, MD, a neurosurgeon, died August 28, 1990. A 1958 graduate of the University of Cincinnati College of Medicine, Dr Wigser had been an associate member of KMA since 1987.

**James L. Stambaugh, MD**  
**Lexington**  
**1927-1990**

James L. Stambaugh, MD, an ophthalmologist, died September 25, 1990. A 1948 graduate of the University of Louisville School of Medicine, Dr Stambaugh was a member of KMA.

**Curtis W. VanHooser, MD**  
**Madisonville**  
**1936-1990**

Curtis W. VanHooser, MD, an internist, died October 5, 1990. Dr VanHooser was a 1962 graduate of the University of Tennessee College of Medicine and an active member of KMA.

**Ernest A. Barnes, MD**  
**Albany**  
**1902-1990**

Ernest A. Barnes, MD, a general practitioner, died October 12, 1990. A 1931 graduate of the University of Louisville School of Medicine, Dr Barnes was a life member of KMA.

**Edward C. Bowling, MD**  
**Lebanon**  
**1923-1990**

Edward C. Bowling, MD, a retired surgeon, died October 21, 1990. A 1952 graduate of the University of Louisville School of Medicine, Dr Bowling was a life member of KMA.

**Robert L. Woodard, MD**  
**Louisville**  
**1914-1990**

Robert L. Woodard, MD, a retired orthopaedic surgeon, died October 22, 1990. A 1941 graduate of the University of Louisville School of Medicine, Dr Woodard was a life member of KMA.

**Byron J. Bizot, MD**  
**Louisville**  
**1908-1990**

Byron J. Bizot, MD, a retired general practitioner, died November 14, 1990. Dr Bizot graduated from the University of Louisville in 1931 and was former secretary and treasurer of the Jefferson County Medical Society. He was a life member of KMA.

## Impaired Physicians Committee

is for the alcoholic/  
chemically dependent  
physician.

For more  
information call

**502-459-9790**



## **RURAL KENTUCKY MEDICAL SCHOLARSHIP FUND**

The Rural Kentucky Medical Scholarship Fund is accepting applications from residents of Kentucky, who have been accepted at the University of Kentucky College of Medicine or the University of Louisville Medical School. The Fund offers a \$10,000 loan for each year of medical school to a qualified recipient who is willing to practice and reside in a rural county in Kentucky for one year for each loan received. The interest rate is determined on May 1. Repayment options include low interest rates for recipients practicing in rural areas and loan forgiveness for those practicing in areas of the state with critical needs. The Fund is the oldest and most successful of its kind in the nation. The Rural Kentucky Medical Scholarship Fund has loaned approximately \$3 million to over 500 medical students. The deadline date for filing an application is **April 1**. Those interested in applying for a scholarship loan should contact the RKMSF Office at the Kentucky Medical Association Headquarters, 3532 Ephraim McDowell Dr, Louisville, KY 40205, or call 502/459-9790.

# **Pfizer Pharmaceuticals First Major Manufacturer to Make Products Available to Kentucky Physicians Care**

Thousands of low-income Kentuckians may receive free prescriptions and pharmacy services through a new program, "Kentucky Pharmacy Providers," that was launched in July 1990.

An agreement has been reached with the Kentucky Health Care Access Foundation, the Kentucky Pharmacists Association, and Pfizer/Roerig Pharmaceuticals to make Pfizer Labs' and Roerig's entire line of prescription drug products available to KPC patients *at no charge*. (To be eligible for the KPC program, patients must have incomes at or below the Federal Poverty Income guidelines and cannot be eligible for any government assistance programs such as Medicare and Medicaid.)

Pfizer Labs and Roerig sales representatives are calling on KPC participating physicians to make them aware of the full range of Pfizer/Roerig products available to KPC, and physicians are encouraged to see them when possible.

In extending this access to prescription drugs, Pfizer will make its Pfizer Labs and Roerig brand pharmaceuticals available at no cost, and participating pharmacists will dispense them without charge to eligible ambulatory patients. The estimated combined value of these goods and services exceeds \$1 million. *Only prescriptions written for Pfizer/Roerig products for KPC eligible patients by KPC participating doctors will be filled through the Kentucky Pharmacy Providers Program.*

The Pfizer and Kentucky Pharmacists Association program will help fill a significant void in KMA's effort to help the less fortunate. The Kentucky Health Care Access Foundation and KPC Operating Committee are hopeful that other manufacturers will offer their assistance in the future.

If you have questions, or for those physicians not currently participating in KPC who wish to participate, please contact the KPC referral office — 1/800/633-8100, or the KMA Headquarters Office — 1/502/459-9790.

**PLEASE REFER TO THE FOLLOWING PAGES  
FOR A LIST OF AVAILABLE  
PFIZER/ROERIG PRODUCTS  
AND A LIST OF PARTICIPATING PHARMACIES**



# Pharmaceuticals available to Kentucky Physicians Care

These Pfizer/Roerig pharmaceuticals may be prescribed and dispensed under the program:

## Pfizer Labs

- Antiminth® (Pyrantel pamoate) OTC  
Cortril® Topical Ointment 1% (Hydrocortisone) Rx  
Diabinese® Tablets (Chlorpropamide) Rx  
Diabinese® Tablets Unit-Dose Pak (Chlorpropamide) Rx  
Feldene® Capsules (Piroxicam) Rx  
Feldene® Capsules Unit-Dose Pak (Piroxicam) Rx  
Minipress® Capsules (Prazosin HCl) Rx  
Minipress® Capsules Unit-Dose Pak (Prazosin) Rx  
Minizide® 1 Capsules (1 mg. Prazosin and 0.5 mg. Polythiazide) Rx  
Minizide® 2 Capsules (2 mg. Prazosin and 0.5 mg. Polythiazide) Rx  
Minizide® 5 Capsules (5 mg. Prazosin and 0.5 mg. Polythiazide) Rx  
Moderil® Tablets (Rescinnamine) Rx  
Procardia® Capsules (Nifedipine) Rx  
Procardia® Capsules Unit-Dose Pak (Nifedipine) Rx  
Procardia XL® (Nifedipine) Extended Release Tablets Rx  
Procardia XL® (Nifedipine) Extended Release Tablets Unit-Dose Pak Rx
- Renese® Tablets (Polythiazide) Rx  
Renese®-R Tablets (2 mg. Polythiazide and 0.25 mg. Reserpine) Rx  
Sustaire® (Theophylline anhydrous) Rx  
Terramycin® Capsules (Oxytetracycline HCl) Rx  
Vansil™ Capsules (Oxamniquine) Rx  
Vibra-Tabs® (Doxycycline hyclate) Rx  
Vibra-Tabs® Unit-Dose Pak (Doxycycline hyclate) Rx  
Vibramycin® Calcium Syrup (Doxycycline calcium oral suspension) Rx  
Vibramycin® Hyclate Capsules (Doxycycline hyclate) Rx  
Vibramycin® Hyclate Capsules Unit-Dose Pak (Doxycycline hyclate) Rx  
Vibramycin® Monohydrate for Oral Suspension (Doxycycline monohydrate) Rx  
Vistaril® Capsules (Hydroxyzine pamoate) Rx  
Vistaril® Capsules Unit-Dose Pak (Hydroxyzine pamoate) Rx  
Vistaril® Oral Suspension (Hydroxyzine pamoate) Rx

## Roerig

- Antivert® (Meclizine HCl) Rx  
Antivert® Tablets Unit-Dose Pak (Meclizine HCl) Rx  
Atarax® (Hydroxyzine HCl) Rx  
Atarax® Tablets Unit-Dose Pak (Hydroxyzine HCl) Rx  
Bonine® Chewable Tablets (Meclizine HCl) OTC  
Cefobid® (Cefoperazone sodium) Rx  
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Diflucan® (Fluconazole) Unit-Dose Pak Oral and Parenteral Antifungal Rx  
Emete-con® IM/IV (Benzquinamide HCl) Rx  
Geocillin® (Carbenicillin indanyl sodium) equivalent to 382 mg. carbenicillin Rx  
Geopen IM/IV (Carbenicillin disodium) Rx  
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Glucotrol® Tablets Unit-Dose Pak (Glipizide) Rx  
Heptuna® Plus Capsules (Iron plus vitamins and minerals) Rx  
Hydrocortisone Powder (Hydrocortisone USP micronized) Rx  
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Navane® Capsules (Thiothixene) Rx  
Navane® Capsules Unit-Dose Pak (Thiothixene) Rx  
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Navane® Intramuscular (Thiothixene HCl) Rx  
Pfizerpen® for Injection (Penicillin G potassium) Buffered Rx
- Pfizerpen®-AS (Penicillin G procaine) Aqueous Suspension Rx  
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Madison Square Drugs & Chymist

**Allen**  
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Williams Pharmacy

**Anderson**  
The Medicine Shoppe

**Barren**  
Ely Drugs, Inc.  
Glasgow Prescription Center  
Tawne & Country Drugs

**Bell**  
Farris Drugs  
Jeff's Pharmacy  
Kroger Company  
Pineville Has. Out-Pt Pharmacy  
SuperX Drugs  
Tatal B. Care Pharmacy

**Boone**  
Baane County Drugs  
Burlington Pharmacy  
SuperX Drugs  
Turfway Pharmacy

**Bourbon**  
Glen's Drugs  
Harne's Ardrey Drug  
The Medicine Shoppe

**Boyd**  
McMeans Pharmacy  
SuperX Drugs

**Boyle**  
Grider Pharmacy  
Leake Pharmacy  
SuperX Drugs  
Taylor Drug

**Bracken**  
Dean's Pharmacy

**Breathitt**  
Jackson Prescription Ctr

**Breckinridge**  
Save-Rite Drugs  
Tawne & Country Pharmacy

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**Caldwell**  
Payless Discount Pharmacy  
The Pharmacy Corner Enterprise

**Calloway**  
Clinic Pharmacy  
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**Christian**  
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Day Drugs  
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**Clay**  
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H & N Drug  
Medi Center Drugs

**Crittenden**  
Glenn's Apothecary

**Cumberland**  
Smith Pharmacy

**Davies**  
Danhauer Drug Company  
Emery Centre Pharmacy  
Greene's Pharmacy  
Harreld's Drug Store  
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Taylor Drug #21  
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Professional Arts Apothecary  
Randall's Pharmacy  
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**Fleming**  
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**Floyd**  
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Mud Creek Clinic Pharmacy  
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**Garrard**  
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Lynch Med. Services Pharmacy  
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**Harrison**  
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Art Jacob Prescription Shoppe  
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Wal-Mart Pharmacies  
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Drug Mart  
Medicine Shoppe  
Taylor Drugs

**Johnson**  
Bi-Rite Pharmacy

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Baeckley Drugs  
Cherakee Drug Shoppe  
Crestville Drugs  
Farrell Pharmacy  
Fart Mitchell Drug Shoppe  
Fart Mitchell Pharmacy  
Ludlaw Drugs  
Medical Village Pharmacy  
Marwessel Drugs  
Nie's Independence Pharmacy  
Save Discount Drugs  
All SuperX Drugs

**Knox**  
Knox Professional Pharmacy  
Sav-Rite Pharmacy

**Laurel**  
Family Drugs  
Kelley's Medical Arts Pharmacy  
Laurel Heights Nursing Home  
Landon City Drug Co.  
Landon-Carbin Pharmacy  
SuperX Drugs

**Lee**  
Stufflebean Pharmacy  
Three Farks Apothecary

**Letcher**  
Parkway Pharmacy  
Shapwise Pharmacy

**Lincoln**  
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Rishie Drugs

**Livingston**  
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Nelson ValuRite Pharmacy  
Pay-N-Save Discount Drugs

### Mason

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Toncray Martor & Pestle

### McCracken

Davis Drugs  
Katterjahn Drug Store  
Kroger  
SuperX Drugs  
The Medicine Shoppe

### McCreary

Burgess Drug Store  
Dougherty Drugs

### Meade

Riverview Pharmacy

### Mercer

Kroger Company  
SuperX Drugs

### Metcalfe

Metcalfe Drugs  
Nunn Drugs

### Montgomery

Calica & Whitt Drug  
Emil W. Baker, Pharmacist  
Ross Drugs  
SuperX Drugs

### Muhlenberg

Beechmont Pharmacy  
Clinic Pharmacy

### Nelson

Snider Drugs

### Nicholas

Carlisle Drug

### Ohio

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Rice Drug Store

### Oldham

Taylor Drugs

### Owsley

Owsley Prescription Center

### Pendleton

Mareland Drug

### Perry

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SuperX Drugs  
Vicca Pharmacy

### Pike

Medical Pharmacy  
Nichals Apatheary  
SuperX Drugs

### Pulaski

Brown's Bogle Street Pharmacy  
Kroger Company  
Somerset Pharmacy  
SuperX Drugs  
The Medicine Shoppe  
Tibbals Drug Store  
Wal-Mart Pharmacy

### Rackcastle

Mt. Vernon Drive-Thru  
Youngs Pharmacy

### Rawan

Cave Run Pharmacy

### Russell

Dougherty Pharmacy  
Hopper Drug

### Scott

Dactor's Park Pharmacy  
Fitch Drug Store  
Kroger Company

### Shelby

Smith-McKenney

### Simpson

Arnold Drug Company  
Prescription Shop  
R. H. Moore Drug Campony  
Shugart & Willis

### Spencer

W. T. Froman Drug Company

### Taylor

Central Drug Center  
Kroger Company  
SuperX Drugs  
The Medicine Shoppe

### Todd

Weathers Drugs

### Trigg

Save On Drugs

### Union

Corner Drug Store  
Professional Drugs #1  
Sturgis Pharmacy

### Warren

Ashley Circle Pharmacy  
C. D. S. #10 Drug  
Clinic Pharmacy  
Medicine Shoppe  
Northgate Pharmacy  
SuperX Drugs  
Taylor Drugs  
Williams Drug Company

### Washington

Caunty Drug

### Wayne

Daffron Drug  
F & H Drug  
Plaza Drugs

### Webster

Providence Pharmacy  
Thrifty Pharmacy, Inc.

### Whitley

Cottongim Drug Company  
Dactors Park Apothecary

### Walfe

Campton Discount Drugs

### Woodford

Corner Drug of Versailles  
Midway Drug  
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Taylor Drugs

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All orders for classified advertising must be placed in writing and will be subject to approval by the Editorial Board. The right is reserved to decline or withdraw advertisements at the publisher's discretion.

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**Please notify us at least  
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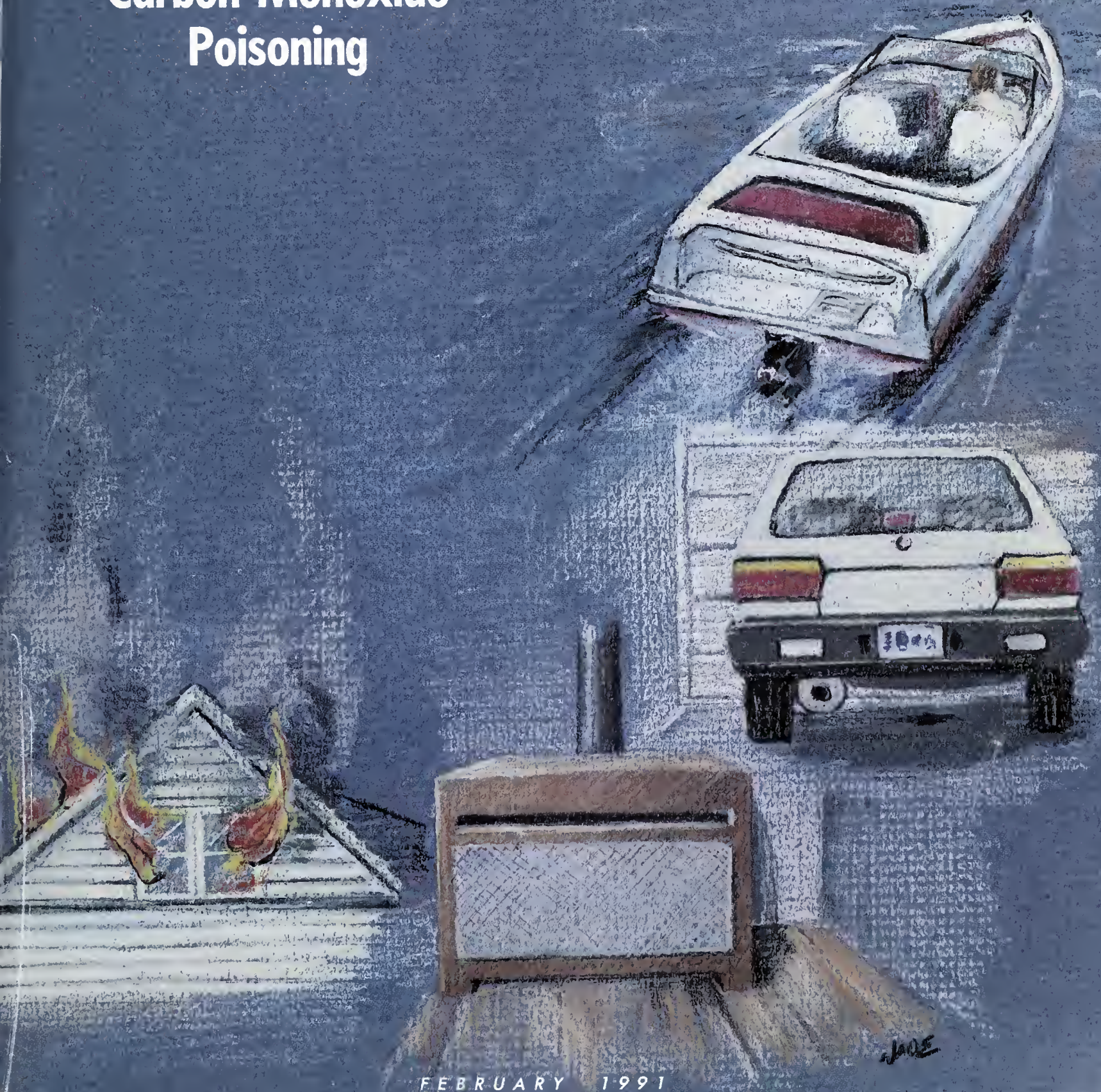


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## Carbon Monoxide Poisoning



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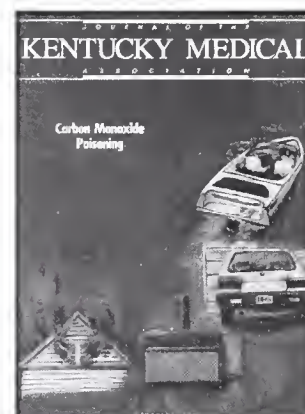
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**COVER:** Illustration by Lee Wade introduces an article on HBO treatment for carbon monoxide poisoning. See page 60.

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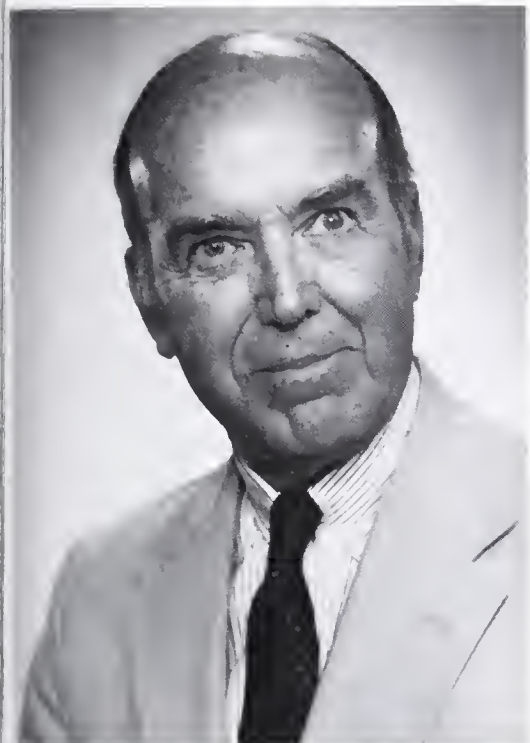
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## A House Divided

**D**eclining revenues, the troubled state of rural health care, and ratcheting down reimbursement by government and private payors bodes ill for the nation's indigent. An estimated 700,000 Kentuckians are without health insurance, with the total increasing every day.

Government and private paying sectors, encumbered with mammoth 20% to 40% annual increases in health insurance premiums, no longer have the will nor sense an obligation to shield the poor by acquiescing to a "sick tax" to offset the cost of indigent care.

The situation is ripe for internecine war between medical specialties aligned along cognitive vs noncognitive and rural vs urban battlefields. The gauntlet has been thrown down in the halls of Congress by various specialty groups confronting each other publicly over reimbursement differences.

Historically, physicians and specialty groups have had scientific, professional, and philosophical differences, but to our credit, we have traditionally rallied around a common goal when the profession is threatened. Unfortunately, there is a growing consensus that a central, all

encompassing, federation can no longer address individual groups' concerns and that differences are so vast that resolution or compromise is unlikely.

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***"The winds of change, while driven by many factors outside one's individual control, will find an ultimate solution within the confines of the public and political arenas."***

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***"Unfortunately, there is a growing consensus that a central, all encompassing, federation can no longer address individual groups' concerns and that differences are so vast that resolution or compromise is unlikely."***

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While we hear a great deal of discussion about RBRVS, PPRC, practice parameters, and other proposals to address budget shortfalls, several things will probably occur in the near future. First, there



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***“Grassroots politics, beginning at the precinct level, provides each of us the opportunity to participate and a voice in the future. USE IT to secure medicine’s future.”***

---

will be an emphasis upon access to primary care. Grumbling among patients seeking primary care is growing as older physicians retire and younger physicians find themselves unable to absorb growing numbers of Medicare, Medicaid, and indigent patients. Primary care physicians, particularly those in rural areas, will likely see growth in reimbursement levels and incomes keeping pace with inflation. Availability and accessibility to basic medical care will be a priority of government as we move toward the 21st century. There is growing disenchantment with increasing specialization and subspecialization. Government and state subsidies for nonprimary care residencies may dry up as health planners and legislators funnel medical students toward physician or specialty shortage areas. Obviously, as the emphasis moves toward primary care, some specialties may see incomes reduced.

An uncertain future creates a climate of suspiciousness and a tendency to make individual deals in “self survival” last-ditch efforts to preserve the status quo. If history has taught us nothing else, it is obvious that our only means of survival is to remain united. We may have to accept things we do not like; however, if government is successful in splintering medicine to such a point that every group is fending for itself, the war is over. In that case we have lost — and the real loser will be the one we most care for — the patient.

While medicine’s future remains

uncertain, I sense a rising interest in medicine. Our younger colleagues face a new world with dramatic innovations in delivery of care, startling advancements in the treatment of disease, and wrenching socioeconomic upheavals in reimbursement mechanisms. The winds of change, while driven by many factors outside one’s individual control, will find an ultimate solution within the confines of the public and political arenas. Decisions on how, when, and where we practice medicine and what the future holds,

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***“If history has taught us nothing else, it is obvious that our only means of survival is to remain united.”***

---

will meet its final resolution in the halls of Congress and chambers of the Kentucky General Assembly. Grassroots politics, beginning at the precinct level, provides each of us the opportunity to participate and a voice in the future. USE IT to secure medicine’s future.

**S. Randolph Scheen, MD  
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SOMETHING TO THINK ABOUT...

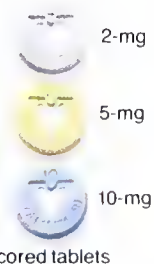
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- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Cecilor penetrates mother's milk. Exercise caution in prescribing for these patients.

#### Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:

- Hypersensitivity reactions have been reported in about 1.5% of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions have been reported with the use of Cecilor. These are characterized by findings of erythema multiforme, rashes, and other skin manifestations accompanied by arthritis/arthralgia, with or without fever, and differ from classic serum sickness in that there is infrequently associated lymphadenopathy and proteinuria, no circulating immune complexes, and no evidence to date of sequelae of the reaction. While further investigation is ongoing, serum-sickness-like reactions appear to be due to hypersensitivity and more often occur during or following a second (or subsequent) course of therapy with Cecilor. Such reactions have been reported more frequently in children than in adults with an overall occurrence ranging from 1 in 200 (0.5%) in one focused trial to 2 in 8,346 (0.024%) in overall clinical trials (with an incidence in children in clinical trials of 0.055%) to 1 in 38,000 (0.003%) in spontaneous event reports. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy; occasionally these reactions have resulted in hospitalization, usually of short duration (median hospitalization = two to three days, based on postmarketing surveillance studies). In those requiring hospitalization, the symptoms have ranged from mild to severe at the time of admission with more of the severe reactions occurring in children. Antihistamines and glucocorticoids appear to enhance resolution of the signs and symptoms. No serious sequelae have been reported.
- Stevens-Johnson syndrome, toxic epidermal necrolysis,

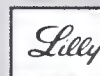
and anaphylaxis have been reported rarely. Anaphylaxis may be more common in patients with a history of penicillin allergy.

- Gastrointestinal (mostly diarrhea): 2.5%
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
- Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertension, dizziness, and somnolence have been reported.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1% and, rarely, thrombocytopenia and reversible interstitial nephritis.

#### Abnormalities in laboratory results of uncertain etiology.

- Slight elevations in hepatic enzymes.
- Transient lymphocytosis, leukopenia, and, rarely, hemolytic anemia and reversible neutropenia.
- Rare reports of increased prothrombin time with or without clinical bleeding in patients receiving Cecilor and Coumadin concomitantly.
- Abnormal urinalysis; elevations in BUN or serum creatinine.
- Positive direct Coombs' test.
- False-positive tests for urinary glucose with Benedict's or Fehling's solution and Clinistest<sup>®</sup> tablets but not with Tes-Tape<sup>®</sup> (glucose enzymatic test strip, Lilly).

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# Hyperbaric Oxygen Treatment for Carbon Monoxide Poisoning: Observations Based on 8 Years Experience

Richard H. Rhodes, MD; Judah L. Skolnick, MD; Thomas M. Roy, MD

*Patients may develop significant carbon monoxide intoxication under a variety of circumstances. We propose that the frequency of symptoms, the patient's presentation, and ultimately the outcome are significantly related to the type of exposure. This association may help the practicing physician maintain the proper index of suspicion for recognizing carbon monoxide poisoning and providing the proper treatment for severe cases.*

## Introduction

Hyperbaric oxygen therapy (HBO) has a sound physiologic basis for hastening recovery from carbon monoxide (CO) poisoning,<sup>1</sup> although a recent observation indicates that there currently is a lack of consensus as to the guidelines and appropriateness of HBO in this situation.<sup>2</sup> A controlled randomized study using this modality in humans is unlikely to be approved by a human studies committee. Until controlled HBO studies using animal models with CO poisoning can be completed, we are limited to examining the performance of this treatment in its present empiric role.

Eight years of continuous operation of a monoplace HBO unit has provided a pool of individuals with CO intoxication severe enough to warrant HBO treatment. Retrospective review of the type of exposure, symptomatology, and clinical outcome forms the basis of this report.

## Methods

A monoplace hyperbaric chamber has been in continuous service under the supervision of one of the authors (JLS) at the Jewish Hospital of Louisville since 1982. We reviewed the HBO unit's records to identify all patients treated for carbon monoxide poisoning. The records of these patients were audited to determine:

1. The etiologies of CO poisoning in our community.
2. If the presentation of severe CO poisoning differed by type of exposure.
3. If a seasonal variation existed in severe CO poisoning and HBO chamber referral.
4. If there has been an increased utilization of HBO for the treatment of CO poisoning during the last 8 years.
5. The outcome of treatment in terms of morbidity and overall survival.

Patients who were referred for HBO treatment for CO poisoning but who were not treated were not included in the data analysis. Statistical analysis was performed using the chi-square test for nonparametric comparisons, the student's T-test for comparison of group means, and one-way analysis of variance (ANOVA) for comparison of more than one group. A p value <0.05 was considered statistically significant.

## Results

From January 1, 1982, to December 31, 1989, there were 74 patients treated for severe carbon monoxide poisoning in the monoplace chamber at Jewish Hospital of Louisville.

There were 44 males and 30 females. The mean age of the group was 34.9 years. There was no statistical difference in the mean ages of the males vs the females. The mean carboxyhemoglobin value for those treated with HBO was 31.8 gm%. There was no significant difference between the males and females.

The etiology of exposure to CO allowed us to conveniently subdivide the individuals into 5 subgroups, ie, suicide attempts, house fires, faulty heaters, occupational exposure, and a miscellaneous group which was exposed to exhaust during recreational or nonoccupational activities.

This subdivision allows more meaningful discussion of the association that exists between



## Hyperbaric Oxygen Treatment for CO

**Table 1.** Demographics of Patients Treated with HBO for CO Poisoning

	Suicide	Faulty Heater	Occupational	House Fire	Misc.	All
Number	n = 20	n = 20	n = 18	n = 8	n = 8	n = 74
Female/Male	6/14	11/9	0/18	6/2	7/1	30/44
Mean Age years	38 ± 16	37 ± 23	33 ± 8	35 ± 35	24 ± 21	35 ± 20
Mean COHb Gm%	33 ± 13	31 ± 9	29 ± 11	36 ± 13	32 ± 15	32 ± 12
Comatose	16/20	3/20	5/18	6/8	2/8	34/74
Death	0	0	1	0	0	1

mode of exposure and expected symptoms (Table).

There was a slight seasonal predominance of severe CO poisoning and HBO treatment during the winter months.

The outcome of therapy was favorable in 73 of 74 patients. One patient subsequently died despite HBO treatment. Complications occurred in only 2 of 74 patients and consisted of a seizure in 1 patient and self-extubation by another while in the chamber. Neither occurrence resulted in death or long-term morbidity.

### Discussion

As physicians have become more aware of the availability of HBO treatment for CO poisoning, especially in the pregnant female,<sup>3</sup> the referral to the HBO unit has steadily increased (Fig 1). This increased utilization has continued in spite of the ongoing controversy about the lack of randomized controlled human studies.

If the clinician's index of suspicion is increased by recognition of the segments of the population likely to have significant CO poisoning and is aware of the criteria for HBO referral, the community may be better served. The clinician should be prepared to gauge the seriousness of the CO exposure by using both presenting symptoms and the COHb level. A recent study indicates that HBO therapy is prescribed for approximately 40% of patients because of an elevated COHb level alone and for 60% of patients because of central nervous system dysfunction, including loss of consciousness, and/or cardiovascular dysfunction.<sup>4</sup>

The complimentary nature of symptoms and COHb levels is evident in our study group if the patients are separated according to the presence or absence of coma. The mean COHb level for

the comatose patients was  $35.3 \pm 12.8\%$  compared to  $28.6 \pm 10.2\%$  for the noncomatose group ( $p = 0.02$ ). This difference is consistent with the published tables that associate loss of consciousness with higher COHb levels. Importantly, however, five patients without coma presented with COHb levels greater than 40% indicating a wide individual tolerance.<sup>5</sup>

Although there is a trend towards greater HBO utilization in the winter months (Fig 2), our analysis by subdivision should alert the clinician to the fact that suicides, house fires, and miscellaneous activities continue to cause significant CO poisoning even in the summer months.

Intentional carbon monoxide inhalation is a common mode of suicide. There were 20 individuals with severe CO intoxication from such self-destructive behavior who were treated with HBO. Eighty percent (16 of 20) of these individuals presented in a comatose state. Nevertheless, none of those treated in the HBO chamber expired. A steady increase in the number of individuals referred to HBO for CO poisoning by suicide has been evident over the last 3 years (15 of 20).

An equally frequent cause of significant CO poisoning treated by HBO in our community was exposure to faulty heating appliances. This type of CO production accounted for 20 individuals. This group was distinguished by its mode of presentation. Only 3 of 20 individuals were comatose. Instead, the symptoms of CO intoxication such as dizziness, nausea, and headache predominated as the exposure was more gradual and insidious than observed in other subgroups. No deaths or complications were noted in this group. A marked increase in the use of HBO for CO poisoning from this source has also been observed over the past 2 years (14 of 20).

Another large group of individuals who sus-

tained significant CO poisoning were individuals who were exposed to machinery exhaust by virtue of their employment. This third largest group referred for HBO treatment contained all males. While the majority of victims experienced confusion, dizziness, and headache as presenting complaints, five of the workers became comatose (5/18-28%). One patient subsequently died. These referrals are predominately in the winter months when outside heating devices must be employed in order to continue outdoor construction or repair. There has not been an increase in HBO referral for this type of exposure to CO.

Since two of the more common sources of severe CO poisoning in our community referred to HBO are occult sources of CO, the physician is reminded to recognize that other people may continue to be at risk and should be warned. The identification of symptomatic cohabitants or co-workers should heighten the suspicion of occult CO poisoning.<sup>6</sup>

Individuals trapped in house fires are at potential risk for fatal CO intoxication. Eight individuals were referred for HBO treatment of CO exposure from this source. The mean age of the group was 35.3 years, ranging from 1 year old to 79 years old. The mean age is misleading, however, and fails to draw sufficient attention to the type of victims in this situation. There was one individual who actually was 34 years old. The others were either very young or elderly. The youngsters were 1, 3, 6, and 9 years old. The elderly were 74, 77, and 79 years old. Obviously, the victims of this type of CO exposure cannot escape the house fire because of their immaturity or because of infirmities associated with old age. Such a distinct bimodal age distribution was not apparent in the other subgroups.

Fire related mortality and morbidity also includes associated trauma, thermal injury, and exposure to other combustion byproducts. It is our strong suspicion that the majority of individuals who receive significant CO intoxication in a house fire generally are dead at the scene. Seventy-five percent of these survivors presented in coma (6 of 8), and another was severely disoriented. None of those referred to HBO treatment subsequently expired. This mode of CO exposure has not resulted in an increase in HBO utilization over the last several years.

The collective subgroup assigned the label "miscellaneous" experienced significant CO exposure not attributable to one of the more common sources listed above. Each of the eight in-

Figure 1.  
HBO TREATMENTS BY YEAR

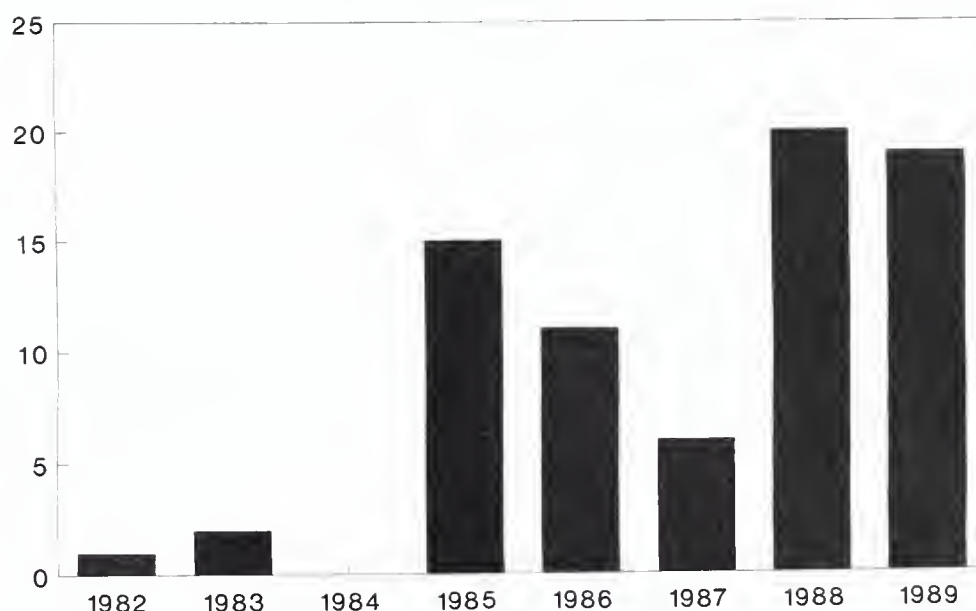
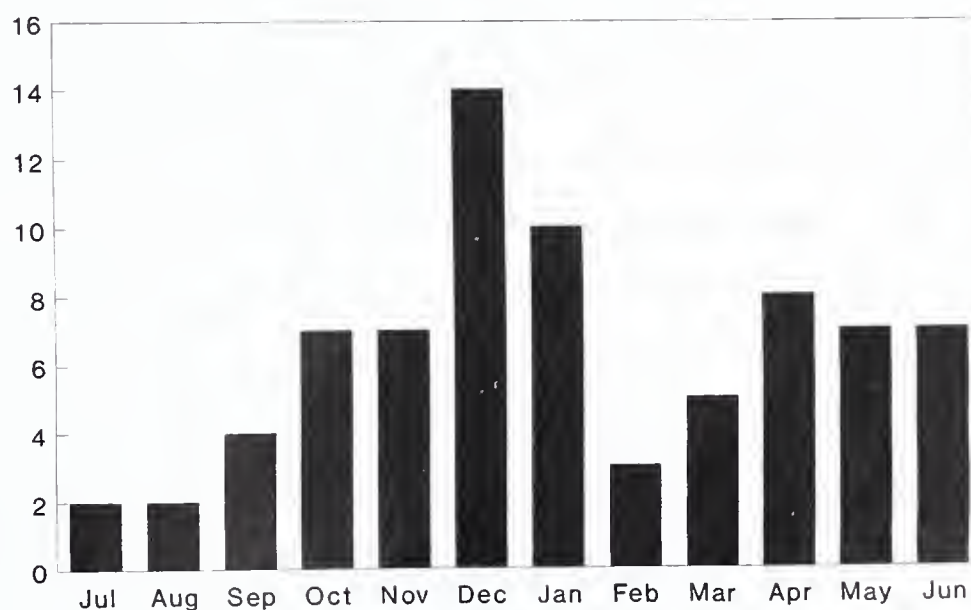


Figure 2.  
HBO TREATMENTS BY MONTH





## Hyperbaric Oxygen Treatment for CO

dividuals in this group were unintentionally exposed to automobile or boat exhaust. Three individuals were poisoned while skiing behind power boats. Three persons were intoxicated by CO while stalled in local traffic jams and two others were overcome while parked in automobiles with the motor running. This subgroup was characterized by coma and collapse which was probably a reflection of increased physical activity or an inability to abandon the vehicles which were the source of exposure.

In summary, 8 years of successful operation of a monoplace HBO unit has allowed us to identify high risk groups and some of the subtleties of their presentation. We hope that these observations will benefit clinicians in the Commonwealth who would like to offer HBO treatment for CO poisoning.

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# Cephalic/Basilic Veins for Aorto-Coronary Bypass: Review, Report and Analysis

John C. Norman, MD; Allan M. Lansing, MD, PhD; Sam F. Yared, MD

Early experimental and clinical attempts to revascularize the myocardium involved implanting the internal mammary artery, without anastomosis, into the myocardium.<sup>2-4, 6-8</sup> A period of transition occurred as evaluation of internal mammary artery implants and the use of reversed saphenous vein autografts with direct anastomosis to the coronary circulation began.<sup>9-13</sup> Use of the cephalic vein as a peripheral vascular graft was subsequently reported. And, as experimental and clinical investigations continued,<sup>14-25</sup> pathologic changes in reversed saphenous vein aorto-coronary bypass grafts were noted.<sup>26-30</sup> Histopathologic,<sup>32-33</sup> angiographic<sup>34-35</sup> and actuarial analyses of the results of internal mammary and reverse saphenous vein aorto-coronary grafting resulted.<sup>36</sup> A report of the use of cephalic and basilic veins in peripheral arterial reconstruction appeared,<sup>37</sup> as others continued to evaluate the early and late morphologic and physiologic results of direct coronary surgery for angina.<sup>38-42</sup> Use of the radial artery as a transposed autogenous graft was proposed.<sup>43</sup> And technical studies of extended (double) internal mammary-coronary artery bypass approaches followed.<sup>44-46</sup> As the need for suitable conduits increased, the use of freeze-preserved saphenous vein allografts was reported,<sup>47</sup> as were interpositions of synthetic grafts<sup>48</sup> between the aorta and the coronary circulation. Other analyses of the use of the radial artery,<sup>49</sup> choosing an appropriate conduit,<sup>50</sup> and prior creation of arteriovenous fistulae to augment the cephalic/basilic veins for use as arterial bypass grafts followed.<sup>51</sup> Interest in the use of arm veins for peripheral arterial construction continued,<sup>52</sup> as did application of cubital venous grafts for aorto-coronary bypass.<sup>53</sup> The use of allogenic saphenous veins was debated<sup>54</sup> and the use of the short saphenous vein as an alternative to the long saphenous was proposed.<sup>55</sup> Cephalic/basilic veins as femoral-popliteal conduits were reported,<sup>56</sup> as were the early and late patency rates of expanded polytetrafluoroethylene grafts in the aorto-coronary

positions.<sup>57</sup> A unique note of use of the umbilical vein for aorto-coronary bypass appeared,<sup>58</sup> along with studies of the use of upper extremity veins alone and in autogenous composite grafts in the infrapopliteal position,<sup>59</sup> femoro-popliteal positions<sup>60</sup> and in the aorto-coronary positions.<sup>61</sup>

## Current Study

With the aforementioned studies in mind we elected to study, directly and indirectly, the results of our use of reversed cephalic/basilic veins in the aorto-coronary position. We found that cephalic/basilic veins had been used quite sparingly over a 10-year period (5.5% of our series). We also found that cephalic/basilic veins were never used as primary grafts, even rarely as secondary grafts, if portions of the greater saphenous or lesser saphenous systems were available, and nearly always resorted to in patients with second or third procedures, when no other autogenous venous conduit was available.

More specifically, we found 55 patients who had reversed cephalic or basilic veins placed in the aorto-coronary position. Thirty-seven of these patients were alive 1 to 10 years following operation. Of the 37, nine had developed recurrent angina within 4 years of operation. Of the 28 without symptoms, 4 were recatheterized 2 to 4 years after operation. Of the 4 recatheterized, 3 cephalic/basilic vein grafts were patent and 1 was occluded.

If recurrent angina in nine of 37 living patients can be attributed to an occluded cephalic or basilic vein graft within 48 months following operation (25%), and one of four cephalic/basilic vein grafts was occluded at angiography 1 to 4 years following operation (25%), then projected actuarial analyses suggest a progressively increasing failure rate with each passing year and a wide disparity in comparison with internal mammary artery or reversed greater saphenous vein grafts placed in the aorto-coronary position.<sup>62</sup>

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## Cephalic/Basilic Veins for Aorto-Coronary Bypass

## Analysis

To develop plausible hypotheses which explain why cephalic/basilic veins are ill-suited as aorto-coronary conduits, pressure/flow, geometry and tissue analyses can be used. Such considerations are based on certain assumptions, ie, that:

1. Upper extremity blood flow is approximately one-half that of lower extremity flow.
2. Cephalic/basilic vein return conduits, therefore [teleologically], have one-half the tensile strength of the greater/lesser saphenous systems.
3. Cephalic/basilic veins in the aorto-coronary position become tortuous and aneurysmal after implantation.
4. Boundary layer flow phenomena are disrupted as turbulence occurs and
5. Thrombosis results.

To explain the development of such proposed tortuosity and aneurysmal dilatation of cephalic/basilic veins in the aorto-coronary position, consider the following:

- a. Most veins follow a reasonably straight course because they are stretched by longitudinal traction. When divided all veins will retract.
- b. Many veins in aged patients often exhibit tortuosities and varicosities.
- c. When pressurized, such veins will elongate, excessively.

In a recent elegant analysis<sup>63</sup> Dobrin and co-workers have explained some fundamental mechanism of the development of arterial tortuosity and aneurysms. These studies, for the current purposes, can be conveniently transposed to the venous system. According to Dobrin's arterial studies, there are two forces that tend to lengthen an artery or [vein]. The first force is due to traction ( $F_T$ ) and is exerted by side branches and perivascular connective tissue. Again, its presence is demonstrated when the vein is transected and the ends retract. This force increases during neonatal development, achieves a maximum in the young adult and declines with age. In harvesting greater/lesser saphenous-cephalic/basilic veins for use in the aorto-coronary position, the branches are divided and the perivascular connective tissue is removed; ( $F_T$ ) is decreased.

The second lengthening force is caused by pressure within the lumen of the vein ( $F_p$ ). This force distends the vein from within, causing extension. In the aorto-coronary position ( $F_p$ ) is arterial, from the ascending aorta, and its effects are more pronounced in the fragile cephalic/bas-

ilic system than in the less fragile greater/lesser saphenous systems. ( $F_T$ ) + ( $F_p$ ) result in the net longitudinal force ( $F_Z$ ) that extends either venous system, in situ or when transposed into the aorto-coronary position. In in-vitro arterial studies Dobrin et al found that as intraluminal pressure ( $F_p$ ) was increased, ( $F_T$ ) decreased subjecting the arteries to nearly constant net longitudinal forces ( $F_Z$ ) until very high pressures were reached. All of these forces ( $F_T$ ), ( $F_p$ ) and  $F_T + F_p$  ( $F_Z$ ) are opposed by a retractive force ( $F_R$ ) exerted by the stretched arterial<sup>63</sup> or venous wall. When the retractive force exerted by the extended artery or vein ( $F_R$ ) is equal and opposite to the net lengthening force ( $F_Z$ ) the partially stretched vessel is at equilibrium and will exhibit a stable length.

If, however, ( $F_R$ ) is inherently inadequate [eg, as in the fragile cephalic/basilic system, even in the young adult in comparison with the greater saphenous/lesser saphenous system] or further decreased from a diminished baseline, with aging, and ( $F_p$ ) is excessive as in the aorto-coronary position, in comparison with lower venous pressures present in situ, then the equilibrium is destabilized and lengthening will occur.

Additionally, the elongating force due to pressure can be related to the product of the luminal pressure and the square of the internal radius. Therefore, the longitudinal force due to pressure ( $F_p$ ) increases exponentially in aneurysmal cephalic/basilic or greater saphenous/lesser saphenous veins in the aorto-coronary position.

Other studies lend credence to these considerations. Age is associated with decreasing retractive force ( $F_R$ ) as the aging vessel wall becomes invested with collagen and loses elasticity.<sup>1,5,31</sup> Dobrin's group has also shown that the retractive force ( $F_R$ ) exerted by the stretched arterial wall is generated almost entirely by elastin. And finally, failure or deficiencies of elastin, in the case of cephalic/basilic veins in the aorto-coronary position causes circumferential dilatation, as well as decreased resistance to extension in the longitudinal direction ( $F_R$ ).

These considerations of pressure, flow, geometry and elastin content can readily explain the inadequacy of the cephalic/basilic venous system as a source for aorto-coronary bypass conduits. They explain our 25% failure rate at 48 months by angiography and a 37% failure rate suggested by premature return of angina symptoms in our current study. They suggest that all cephalic/basilic veins in the aorto-coronary position will elongate, become tortuous and/or

aneurysmal, will develop disturbed flow patterns and will, thereby, thrombose at a rate that is unacceptable for long-term ( $\geq 10$  year) expectations. When no other tissue is available, they represent a viable solution to a vexing problem.

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# Drug-Induced Pleural Effusions

Ryland P. Byrd, MD; Cathleen J. Morris, MD; Thomas M. Roy, MD

*Systematic analysis of pleural fluid, in conjunction with the patient's clinical presentation, should allow the clinician to arrive at the correct diagnosis in approximately 90% of cases. An awareness that some commonly used pharmaceutical agents can cause pleural effusion may help the clinician recognize the pathogenesis of some effusions whose cause is less obvious.*

## Introduction

**A**lthough over 40 pharmaceutical agents have been implicated in causing parenchymal lung disease, only a few drugs have been incriminated in the production of pleural disease with effusion. The clinician needs to be aware of those agents with the potential of causing pleural effusion, since the fluid usually represents a hypersensitivity reaction and will not abate until the offending drug is withdrawn.

We present a patient with a large right-sided pleural effusion which was determined by the proper laboratory tests to be secondary to his antiarrhythmic medication, procainamide. We update the diagnosis of drug-induced pleural effusion from drugs causing the lupus-like syndrome and provide a review of other medications recognized to cause pleural effusion.

## Case Report

RR, a 61-year-old white male, was admitted for evaluation of shortness of breath and a right-sided pleural effusion. He had developed fever, dyspnea, nonproductive cough, myalgias, and arthralgias approximately 4 weeks earlier. During that time he had been hospitalized with a provisional diagnosis of lower respiratory infection and was treated with intravenous Cephalothin. He had been discharged on Cefaclor with only minimal improvement in his symptoms. A chest radiograph obtained 2 weeks after discharge revealed the right-sided pleural effusion that prompted this admission.

His past medical history was significant for atherosclerotic coronary artery disease which necessitated coronary artery bypass surgery 6 months

earlier. An automatic implantable cardiac defibrillator had also been placed during surgery because of recurrent malignant ventricular ectopy despite antiarrhythmic therapy. The patient had also undergone a right below-the-knee amputation for osteomyelitis 5 years earlier.

The patient's medications at the time of admission were Procan SR 1000 mg qid, as well as digoxin, furosemide, warfarin, and potassium supplement. He had no prior history of tobacco or alcohol use.

His physical examination revealed a well developed, well nourished individual in mild respiratory distress, but without conversational dyspnea. He was afebrile and the respiratory rate was 14 breaths per minute. Examination of the head and neck was normal with particular attention for jugular venous distention and lymphadenopathy. Diminished breath sounds were noted in the right base, where tactile fremitus was absent and resonance was decreased. The left lung examination was normal. The cardiac rhythm was regular with a rate of 90/min. Auscultation confirmed the presence of a II/VI systolic ejection murmur which had been documented on earlier admissions. The remainder of the physical examination was unremarkable except for his well healed surgical scars and surgical absence of the right lower extremity.

A lateral decubitus chest film showed some free flowing pleural fluid, although a considerable amount of fluid was loculated anteriorly in the area of pericardial adhesions from the cardiac surgery. Laboratory studies measured the hemoglobin of 14 gm/dl and a white blood count of 9,200 with a normal differential. Serum electrolytes were normal. Serum LDH was 163 IU. Total protein was 6.9 gm/dl, with an albumin of 3.6 gm/dl. The ESR was increased to 64 mm/hr. Rheumatoid factor was negative, but the serum ANA was recorded at a titer of 1:2560 with a homogeneous pattern. Procaine level was high at 50 mEq/ml and the NAPA level was 14 mcg/ml. Urinalysis was normal.

A thoracentesis was performed on the second hospital day with removal of 80 cc of straw-colored fluid which was exudative in nature. The

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total pleural fluid protein was 5.1 gm/dl with an LDH of 770 IU. The white blood cell count of the pleural fluid was 5,500 with a predominance of polymorphonuclear cells. Red blood cell count was 20,000. No organisms were found on Gram's stain or examination for fungal or mycobacterial organisms. Cytologic examination was negative for malignant cells. The pleural fluid ANA titer was recorded at 1:5120. The pleural fluid to serum ANA ratio was 2.0.

Based on the patient's clinical presentation and the characteristics of the pleural fluid, the diagnosis of a lupus-like, drug-induced pleural reaction with effusion was made. Procainamide was discontinued and an alternate antiarrhythmic was started. Without further treatment, the patient's symptoms and pleural fluid completely resolved.

### Discussion

By far the most common mechanism of drug-induced pleural effusion, as exemplified by our case report, is by a drug-induced lupus-like syndrome. The drugs that are most commonly implicated are procainamide, hydralazine, isoniazid, phenytoin, quinidine, and chlorpromazine.<sup>1</sup> Procainamide is currently the most frequent offender, because of its popularity as an antiarrhythmic agent. It has been estimated that two-thirds of patients presenting with procainamide-induced lupus will demonstrate pleuropulmonary involvement at some time.<sup>2</sup> The patient will commonly experience pleurisy and may develop radiographic evidence of pleural effusion. Dyspnea, fever, and polyarthralgias may also occur. Pulmonary interstitial fibrosis may or may not be radiographically apparent to aid in making the proper diagnosis. Renal involvement is characteristically absent in the drug-induced lupus syndrome.

The pleural fluid is characteristically exudative with elevated pleural fluid to serum ratios for protein and LDH.<sup>3</sup> Antinuclear antibodies will be positive in both the serum and the pleural fluid. When laboratories still performed the SLE cell preparation on pleural fluid this finding was diagnostic.<sup>4</sup> Today, however, we depend on the pleural fluid titer of the antinuclear antibody (ANA) or the pleural fluid to serum ANA ratio to confirm the diagnosis. A pleural fluid ANA titer of 1:160 or greater or a pleural fluid/serum ANA ratio greater than 1.0 supports the diagnosis of a pleural effusion caused by drug-induced lupus.<sup>5</sup> Specific

nuclear fluorescence of ANA can be demonstrated in pleural biopsy specimens from patients with procainamide-induced pleural disease, but this invasive procedure is rarely required.<sup>6</sup>

There are scattered reports of the other compounds mentioned above causing parenchymal lung disease with occasional pleural effusions. Hydralazine in particular has been noticed to affect women more often than men. The phenomenon appears to be dose related with no cases reported when the dosage has been maintained at less than 50/mg day. On the other hand, the incidence of pleuropulmonary disease increases to 10% when doses greater than 200 mg/day are used for 4 years.<sup>7</sup>

Most practicing clinicians are aware of the interstitial disease that may occur as a hypersensitivity reaction to nitrofurantoin. It is less well known that both the acute and chronic reactions can be associated with pleural fluid accumulations. The acute and chronic pleuropulmonary reactions differ, however, in manner in which the pleural effusion presents. In the acute reaction, the patient commonly presents with fever, dyspnea and cough. Alveolar and/or interstitial infiltrates may occur radiographically, but 8% of the patients will present with only pleural effusions. Eosinophils occur in the peripheral white blood cell profile as well as in the pleural fluid. In contrast, 7% of the patients with a chronic reaction will develop pleural effusion but never develop it in the absence of concomitant parenchymal infiltrate or fibrosis.<sup>8</sup>

Dantrolene is an agent used for skeletal muscle relaxation. It has a chemical structure similar to nitrofurantoin and has the ability to produce a pleural effusion without parenchymal involvement. This effusion will closely mimic the effusion seen in the acute nitrofurantoin reaction with an eosinophilic composition. The patient may be asymptomatic or may have pleuritic chest pain and fever. Symptoms and effusions resolve without sequelae within days after the discontinuance of the medication.<sup>9</sup>

Methysergide, an agent sometimes needed in the treatment of vascular headaches, has the potential to produce an acute pleural reaction with fever, pain, and dyspnea. The radiographic evidence of this pleural reaction may be demonstrated as pleural effusions which tend to localize, pleural nodules, and occasionally parenchymal fibrosis. Interestingly, this phenomenon usually affects the older patient ranging in age from 50 to 60 years. The symptoms resolve com-

**Table:** Drugs reported to have caused pleural effusions.

Amiodarone\*  
 Bleomycin\*  
 Bromocriptine\*  
 Chlorpromazine  
 Dantrolene\*  
 Hydralazine  
 Isoniazid  
 Methotrexate\*  
 Methysergide\*  
 Mitomycin  
 Nitrofurantoin\*  
 Phenytoin  
 Procainamide\*  
 Quinidine

\*Have been reported to cause pleural effusion without radiographic evidence of accompanying parenchymal disease.

pletely when the drug is discontinued. The amount of residual fibrosis serves as a marker for the lag time between the onset of symptoms and the withdrawal of the medication.<sup>10</sup>

Methotrexate, an agent used in cancer chemotherapy and systemic immunosuppression, can also cause pleural effusion without parenchymal infiltrates. Unlike other agents discussed here, pleural effusion has occurred after only a single dose. The incidence of pleural effusion may be as high as 9%. The usual expression of the pleural reaction is that of chest pain and effusion developing after the third or fourth dose. Interestingly the levels of circulating methotrexate are normal. When the effusions resolve, persistent pleural thickening may remain and be followed by evidence of parenchymal disease.<sup>11</sup>

Some patients who suffer from Parkinson's disease benefit from the administration of bromocriptine. Unfortunately, there is a 6% incidence of pleural thickening and effusion. The mechanism is unknown, but the histology is that of chronic fibrosing pleuritis.<sup>12</sup>

Amiodarone is notorious for alveolitis with resultant parenchymal infiltrates and fibrosis. Pleural thickening and effusions are much less common, but when they occur they may be massive and suggest neoplasm. The dose required to incite such a reaction has usually been greater than 100 mg/day. Steroids are usually required to ameliorate the symptoms.<sup>13</sup>

Mitomycin more commonly causes interstitial disease and noncardiac pulmonary edema. Nevertheless, patients may develop pleural effusions. This rarely occurs, however, in the absence of interstitial lung involvement.<sup>14</sup>

Bleomycin will induce pulmonary toxicity in 6% to 10% of patients treated with greater than 450 units. The major reaction is that of interstitial pneumonitis with fibrosis, but occasionally an accompanying pleural effusion will occur.<sup>15</sup>

The list of pharmaceutical agents currently associated with pleural effusions (Table) will most certainly continue to expand. Awareness of those drugs that are capable of promoting pleural reactions may help the clinician clarify the etiology of a pleural effusion that develops in a patient after the institution of pharmacotherapy. Analysis of the pleural fluid for ANA and the calculation of the pleural fluid/serum ANA ratio are helpful confirmatory measures if a drug-induced lupus syndrome is entertained.<sup>16</sup> The presence of eosinophils in the pleural fluid of a patient receiving

nitrofurantoin or dantrolene should also strongly suggest a drug etiology.

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# Post-Arthroscopic Pulmonary Edema in Two Healthy Teenage Athletes

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*Outpatient arthroscopic knee surgery carries with it certain risk factors similar to those accompanying other major knee procedures. These risks may be related to the complexity of the procedure, exposure to anesthesia, or risk factors from previous medical history. Two cases of acute pulmonary edema following arthroscopic knee surgery in otherwise healthy teenage athletes are presented. Both patients developed acute respiratory distress in the recovery room after uneventful arthroscopic knee surgery. The patients in both cases recovered and were able to return to sporting activity with no sequelae. The similarities in both cases prompted a retrospective investigation of the events from the induction of general anesthesia to the admission of the patients to the intensive care unit. Several possible causes of acute post-operative pulmonary edema include fluid overload, cardiac arrhythmia, respiratory depression, systemic drug reaction and sickle cell trait or disease. Outpatient arthroscopy still remains the procedure of choice for meniscal pathology of the knee, but the surgeon and the anesthesia personnel must be aware of and prepared for pulmonary complications that may arise in the immediate post-operative period.*

Outpatient arthroscopic knee surgery carries with it certain risk factors similar to those accompanying other major knee procedures. These risks may be related to the complexity of the procedure, exposure to anesthesia, or risk factors from previous medical history. Patients at risk for elective surgery include those with a history of allergies to medications, cardiovascular disease, pulmonary disease, bleeding disorders and certain metabolic diseases. Other risk factors from the patient's family history include malignant hyperthymia, myasthenia gravis, and sickle cell trait or disease. In some cases risks involving anesthesia are unknown to the patient because of no prior exposures. This is more

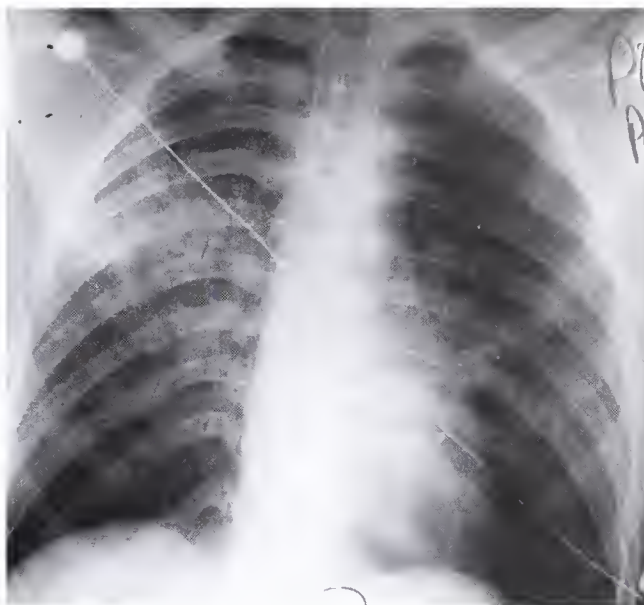
often the case with the young, healthy, athletic population which presents for arthroscopic knee surgery.

The morbidity associated with arthroscopic surgery reported in the literature ranges from less than 1% to 15%.<sup>1-3</sup> In one series approximately 5% of complications were directly attributed to anesthesia.<sup>4</sup> These complications included hypotension or rash (following local anesthesia), aspiration, and hypotension or post-operative nausea (following general anesthesia). Other known complications are fluid overload, cardiac arrhythmias, respiratory depression, and systemic drug reactions resulting in respiratory arrest.

We present two cases of acute pulmonary edema following arthroscopic knee surgery in otherwise healthy teenage athletes. Both patients developed acute respiratory distress in the recovery room after uneventful arthroscopic knee surgery. Both developed acute bilateral pulmonary edema which required reintubation and pulmonary resuscitation in the intensive care units. The patients in both cases recovered and were able to return to sporting activity with no sequelae. The similarities in both cases prompted a retrospective investigation of the events from the induction of general anesthesia to the admission of the patients to the intensive care unit.

## Case Report

A.S. is a 16-year-old black male athlete who injured his left knee playing football. Clinical examination revealed a moderately swollen knee. Ligaments were stable and positive findings included lateral joint line tenderness and a positive McMurray's sign involving the lateral meniscus. Radiographs of the knee were normal. The clinical diagnosis was a lateral meniscus tear, and arthroscopy was recommended. Informed consent was obtained. Past medical history revealed a positive family history for asthma and a negative history for sickle cell trait or disease. The patient had no prior surgeries or exposure to anesthesia.



**Fig 1 — A.S. A-P chest x-ray demonstrating bilateral pulmonary infiltrates.**

The patient was taken to the operating room where a partial lateral meniscectomy was performed under general anesthesia. Total operating time was 75 minutes. A tourniquet was not used during this procedure. The patient received 1 gm of cephalosporin pre-operatively.

Anesthesia was induced with 500 mg pentobarbital, 120 mg succinylcholine and 100 mg lidocaine. Anesthesia was maintained with halothane in nitrous oxide. Two and one-half milligrams of droperidol were given intra-operatively. A.S. received 1100 ml of crystalloid during the procedure. He also received 20 ml of 0.5% bupivacaine intra-articularly at the time of removal of the arthroscope. The patient's vital signs were stable at the time of extubation, and there were no cardiac or pulmonary problems noted during the surgery. This patient did not receive Narcan for reversal of anesthesia.

Upon arrival in the recovery room the patient was noted to have labored respirations with decreased tidal volume. The patient was immediately reintubated, and pink frothy fluid was removed from the endotracheal tube. A stat chest x-ray demonstrated bilateral fluffy infiltrates possibly consistent with pulmonary edema (Fig 1). His initial blood gases were: PH 7.28,  $PCO_2$  50,  $PO_2$  25,  $O_2$  SAT 38% and  $HCO_3$  25. He was transferred to the intensive care unit. Administration of 10 mg furosemide improved his clinical course, and his blood gases returned to normal. The patient continued to improve, demonstrating clearing of the lung fields on auscultation as well as on repeat x-rays. The patient was extubated 5 hours later after normal blood gases were obtained. The patient was discharged on the second post-operative day. Follow-up examinations revealed no sequelae from the knee surgery or the pulmonary edema, and he was able to return to athletics within 1 month of surgery.

A.S. underwent a second arthroscopy of his left knee for a new injury 3 months later. He had no complications from the second procedure.

#### Case Report

K.W. is a 17-year-old black male football player who injured his right knee in practice. His history was consistent with a valgus external rotation injury with a persistent effusion, possible patellar instability and a possible osteochondral injury or free floating loose body. Arthroscopy was recommended. Informed consent was obtained. Past medical history revealed exercise-induced asthma, meningitis (age 10) and sickle cell trait. He had undergone no previous major surgeries or general anesthesia. He used a bronchodilator as needed during exercise.

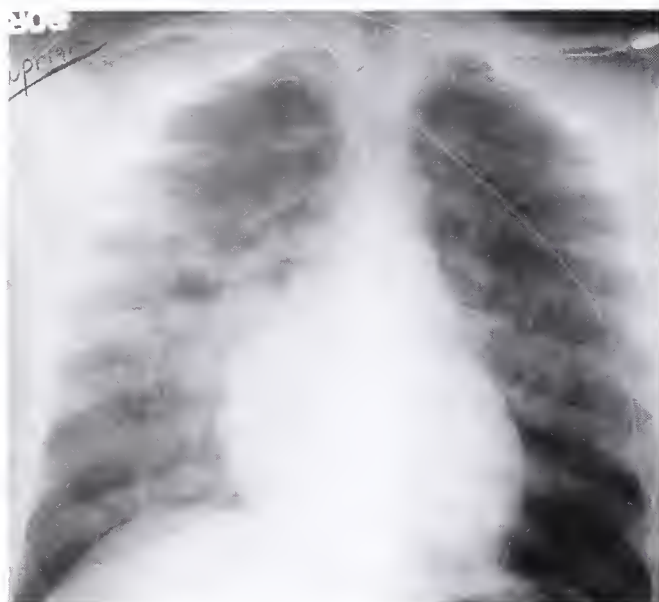
The patient was taken to the operating room where, under general anesthesia, a loose body was removed and shaving of the patellar undersurface was performed without difficulty. Total operating time was 65 minutes. A tourniquet was not used during this procedure. The patient received 1 gm of cephalosporin and 1 mg midazolam preoperatively.

Induction agents used were 500 mg pentobarbital, 140 mg succinylcholine, 100 mg lidocaine, 3 mg curare, and 1.2 mg droperidol and 1 cc fentanyl. Anesthesia was maintained with nitrous oxide and isoflurane. K.W. received 800 ml of crystalloid during this procedure. He also received 20 ml of 0.5% bupivacaine intra-articularly at the time of removal of the arthroscope. Anesthesia reversal was attempted with 0.1 mg Naloxone IV. Vital signs were stable at the time of extubation.

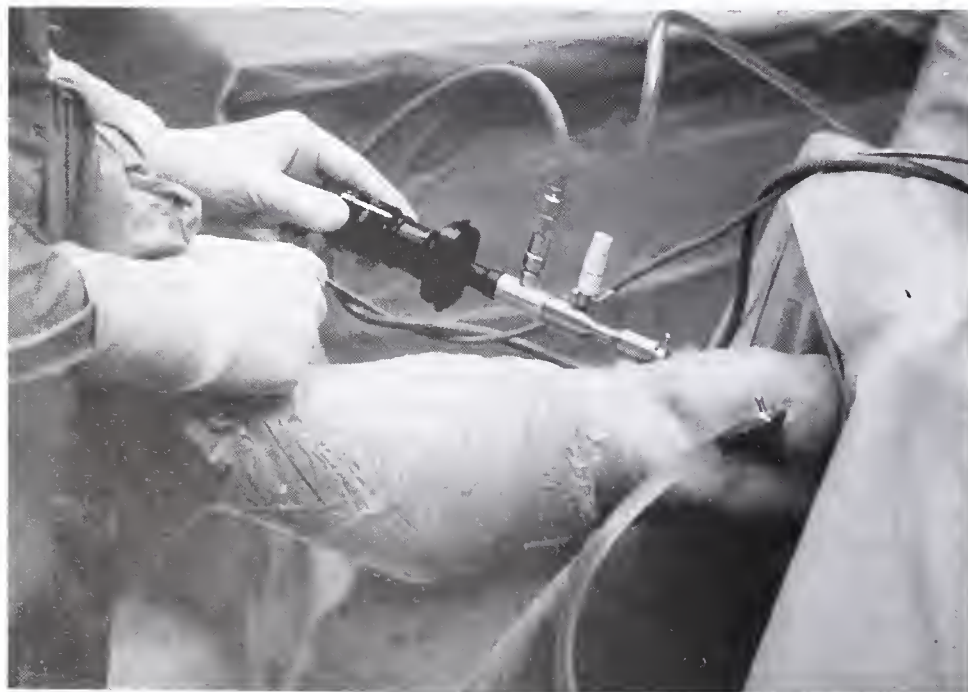
The patient was transferred to the recovery room where respiratory depression was noted. A



## Post-Arthroscopic Pulmonary Edema



**Fig 2 — K.W. A-P chest x-ray demonstrating bilateral pulmonary infiltrates.**



**Fig 3 — Arthroscopic technique for the knee.**

second dose of 0.2 mg naloxone IM was given. No improvement was noted and a third dose of 0.1 mg naloxone IV was administered. The patient became agitated and vomited. An oral airway was placed. Pink frothy sputum was noted.

The patient was reintubated and placed on a ventilator (12/min  $\times$  900 cc on 35% O<sub>2</sub> with 3 mm hg of peep). The patient was then given 4 mg IV morphine sulphate and 10 mg vecuronium bromide IV. A stat chest x-ray demonstrated bilateral fluffy infiltrates (Fig 2). Initial blood gases were PH 7.17, CO<sub>2</sub> 62, PO<sub>2</sub> 108, O<sub>2</sub> SAT 96, Base Excess -5.9, HCO<sub>3</sub> 23. Patient was given 1 mg lorazepam for restlessness. Blood gases improved to PH 7.29, CO<sub>2</sub> 48, PO<sub>2</sub> 452, O<sub>2</sub> SAT 100%, Base Excess -2.7, HCO<sub>3</sub> 24. He became alert and restless. His restlessness was treated with a total of 12 mg midazolam. His condition continued to improve, and his blood gases remained normal. Chest x-rays demonstrated clearing of the lung fields. The patient was extubated 6 hours later and was discharged on the fourth post-operative day. Follow-up examinations revealed no sequelae from the knee surgery or the pulmonary edema, and he returned to his former level of athletic participation.

### Discussion

At the University of Kentucky, outpatient arthroscopic surgery is the treatment of choice for patients undergoing knee procedures other than major ligament repairs or reconstructions. From December 1987 to September 1990, we performed 450 arthroscopic knee procedures. All procedures were performed under general anesthesia or regional anesthesia. All patients were given cephalosporin preoperatively. The other medications for the induction of anesthesia were given under the direction of the anesthesiologists.

In arthroscopic procedures, the knee is placed in an arthroscopic leg holder, prepped, and draped under sterile conditions. A three-portal technique for arthroscopic inspection and surgery is used in all cases (Fig 3). A tourniquet is placed about the proximal thigh but is not routinely used during the procedure. At the conclusion of the procedure, all knees are injected intra-articularly with a 0.5% Marcaine solution. A sterile bandage consisting of adaptic, 4  $\times$  4's, abdominal sponges and a 6" ace wrap is placed about the patient's knee. Post-operative instructions are given for weight

bearing, wound care, pain medications and return to clinic.

Pulmonary edema rarely occurs in healthy patients as a post-anesthetic complication. Situations which contribute to the development of acute pulmonary edema in the post-operative patient have been identified as fluid overload,<sup>5</sup> aspirations, drug reaction, stridor and cardiac failure.<sup>6-9</sup> Other causes include a medical history such as asthma, sickle cell trait and/or disease, allergies, and previous exposures or problems with anesthesia.<sup>10-14</sup> The amount of fluid administered by anesthesia or the amount of irrigation fluid used at the time of arthroscopy is unlikely to cause pulmonary edema in a healthy patient.

Sickle cell trait, although usually considered a benign, asymptomatic condition, has been observed to contribute to pulmonary edema in patients subjected to hypoxemia, acidosis or hypothermia during anesthesia. It is important to screen all black surgical patients for sickle cell trait or disease.<sup>11-14</sup> Poor ventilation resulting in hypoxia may be enough to push a patient into a crisis. Prior knowledge of sickle cell trait by the anesthesia personnel will help in avoiding factors that precipitate a sickle crisis. Factors during anesthesia which may help in preventing a crisis are warming the inspired gases, warming the IV fluids, warming the operating room and the patient, and ensuring adequate hydration. Our patient with the history of sickle cell trait was adequately monitored during the procedure, and it was felt that the pulmonary complication was not directly related to this.

Reports cite cases of post-operative pulmonary edema associated with drug administration for the reversal of anesthesia.<sup>7-9</sup> Possible etiologies include a type of neurogenic pulmonary edema following intravenous naloxone. Naloxone-induced catecholamine release causes pulmonary hypertension and subsequent increased pulmonary vascular permeability. It is also possible that a peripheral opioid receptor may interact with naloxone to incite pulmonary edema. Lack of anaphylactic symptoms in these cases and in those cited in the literature preclude an allergic origin. However, positive pressure ventilation may slow the onset of pulmonary edema; this may explain the delayed onset. Force expiration against a closed glottis is also a cause of respiratory distress in the post-operative period that may lead to the development of bilateral pul-

monary interstitial edema. This occurs when extubation is performed prematurely. In both cases we did not feel that this was the cause.

Although aspiration of acidic gastric contents may cause pulmonary edema in the post-operative patient,<sup>17</sup> the onset is not immediate as in the two cases presented here. Fat embolism leads to the leaky capillary syndrome.<sup>16</sup> This may cause pulmonary edema. However, there is no reason to believe that the fat embolism occurred in these patients, because of the time period in which the pulmonary edema developed. Fat embolism usually takes 24-36 hours to develop and is usually associated with long bone trauma.

A common pharmacological variable in these two cases was the intra-articular injection of bupivacaine. The literature reports numerous cases of respiratory arrest but not pulmonary edema due to inadvertent intravascular administration or absorption of bupivacaine.<sup>18-20</sup> Bupivacaine can cause acute neurologic respiratory depression. Given the high permeability of the synovium, systemic absorption of bupivacaine is reasonable, although we do not have blood levels to support this in these two cases.

Pulmonary edema in these two young athletes who underwent outpatient arthroscopic procedures is a rare occurrence. We have retrospectively reviewed several possible causes of pulmonary edema, none of which satisfactorily explains these two cases. The connection between bupivacaine administration and the rapid development of pulmonary edema with other factors surrounding the use of general anesthesia is unlikely.

A careful medical history must be available in all surgical cases. A history of previous pulmonary disease or complications is important. The positive history of sickle cell trait must be taken seriously in preparing a young black athlete for the operating room. Adequate hydration, as well as warming of the inhalants and the operating room, may help. Careful monitoring of fluids and medications given in the operating room is important in avoiding over-hydration and over-dosage.

Intra-articular bupivacaine carries a risk of systemic absorption which may be avoided by the use of a smaller dosage or a diluted concentration. Outpatient arthroscopy still remains the procedure of choice for meniscal derangement of the knee, but the surgeon and the anesthesia per-



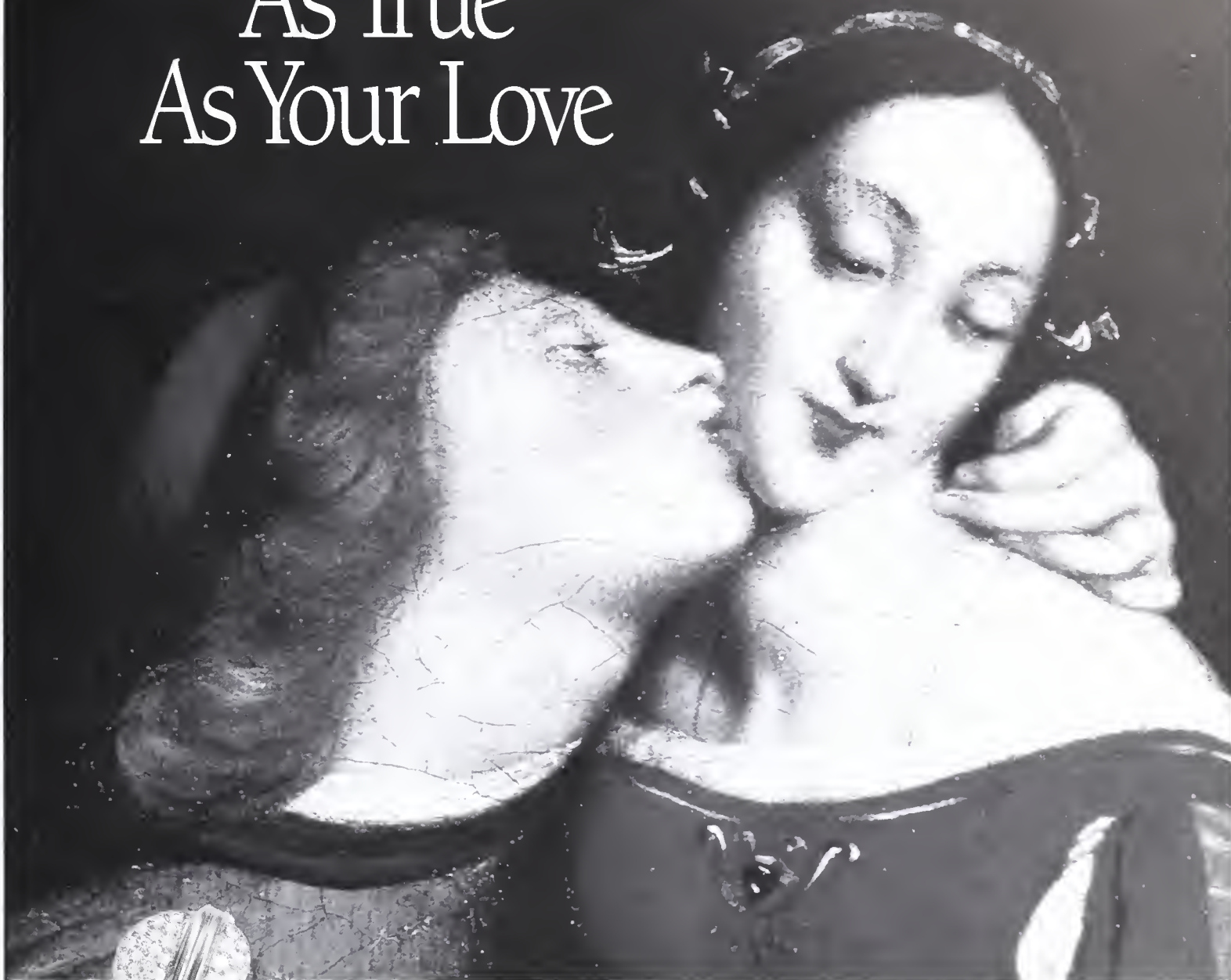
## Post-Arthroscopic Pulmonary Edema

sonnel must be aware of and prepared for pulmonary complications that may arise in the immediate post-operative period.

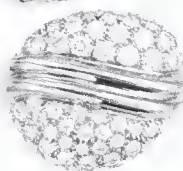
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# As True As Your Love



Detail: *Paolo and Francesca*, Jean-Auguste-Dominique Ingres, 1780-1867



Express your true feelings  
with an exquisite diamond  
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## FEBRUARY

**24-March 1 — 22nd Family Medicine Review, Session I;** Hyatt Regency Hotel, Lexington, KY. Contact: Ms Joy Greene, Director CME, 132 College of Medicine Office Bldg, U of K, Lexington, KY 40503-0086; 606/233-5161.

## MARCH

**2-7 — American Society of Clinical Pathologists/College of American Pathologists 1991 Spring Meeting,** Opryland Hotel, Nashville, TN. Open to all ASCP/CAP members and non-members in anatomic and clinical pathology and laboratory medicine. Contact: American Society of Clinical Pathologists, 800/621-4142 (in Illinois, 312/738-4890).

**8-9 — 4th Annual Contact Lens Course,** Washington University Medical Center, St. Louis, MO. Contact: Cathy Caruso, Office of CME, Washington University School of Medicine, 660 S Euclid, Box 8063, St. Louis, MO 63110; 800/325-9862 or 314/362-6893.

**13-15 — Seventeenth International Symposium on Psychopharmacology,** Holiday Inn-Hurstbourne, Louisville, KY. Contact: Laura Tucker, CME, University of Louisville, Louisville, KY 40292; 502/588-5329.

**22-23 — Kentucky Thoracic Society 36th Annual Scientific Conference on Pulmonary Disease,** Radisson Hotel, Louisville, KY. Contact: Barry Gottschalk, PO Box 9067, Louisville, KY 40209-0067; 502/363-2652.

**25 — Dean's Hour — W. O. Johnson Lecture,** University of Louisville Health Sciences Center Auditorium, Louisville, KY. Contact: Laura Tucker, CME, University of Louisville, Louisville, KY 40292; 502/588-5329.

## APRIL

**4-5 — Operative Gynecologic Endoscopy,** University of Louisville Health Sciences Center Instructional Bldg, Louisville, KY. Contact: Laura Tucker, CME, University of Louisville, Louisville, KY 40292; 502/588-5329.

**11-13 — Treatment of Surgical Spine Disease,** The Ritz-Carlton Hotel, St. Louis, MO. Presented by Washington University School of Medicine. Contact: Cathy Caruso, Office of CME, Washington University School of Medicine, 660 S Euclid, Box 8063, St. Louis, MO 63110, 314/362-6893.

**12-13 — General Endocrine Review;** Hyatt Regency Hotel, Lexington, KY. Contact: Ms Joy Greene, Director CME, 132 College of Medicine Office Bldg, U of K, Lexington, KY 40503-0086; 606/233-5161.

**14-17 — 59th Annual Assembly, Southeastern Surgical Congress;** Hotel Intercontinental, New Orleans, LA. Contact: Roger Sherman, MD, 69 Butler St, SE, Suite 314, Atlanta, GA; 404/221-0570.

**19-21 — Sports Medicine for Physicians;** Hyatt Regency Hotel, Lexington, KY. Contact: Ms Joy Greene, Director CME, 132 College of Medicine Office Bldg, U of K, Lexington, KY 40503-0086; 606/233-5161.

**25-26 — 18th Annual Obstetrics and Gynecology Symposium.** Washington University School of Medicine. Contact: Cathy Caruso, Office of CME, Washington University School of Medicine, 660 S Euclid, Box 8063, St. Louis, MO 63110; 800/325-9862, 314/362-6893.

**25-27 — High Risk Pregnancy Postgraduate Course,** Hyatt Regency Hotel, Louisville, KY. Contact: Laura Tucker, CME, University of Louisville, Louisville, KY 40292; 502/588-5329.

**26-27 — Contemporary Pediatrics for the Practicing Physician;** Hyatt Regency Hotel, Lexington, KY. Contact: Ms Joy Greene, Director CME, 132 College of Medicine Office Bldg, U of K, Lexington, KY 40503-0086; 606/233-5161.

## MAY

**10-11 — Nineteenth Annual C. Dwight Townes Symposium,** The Seelbach Hotel, Louisville, KY. Norman S. Jaffee, MD, senior American surgeon in the field of lens implantation, will give Townes lecture; William Tasman, MD, ophthalmologist-in-chief at Wills Eye Hospital,

will discuss retinal diseases and their treatment; and section on new neurodiagnostic testing presented. Contact: Mrs Rodman, 502/588-5466.

**18 — Nephrology Seminar,** University of Louisville Health Sciences Center Auditorium, Louisville, KY. Contact: Laura Tucker, CME, University of Louisville, Louisville, KY 40292; 502/588-5329.

**19-24 — Twenty-Second Family Medicine Review — Session II;** Hyatt Regency Hotel, Lexington, KY. Contact: Ms Joy Greene, Director CME, 132 College of Medicine Office Bldg, U of K, Lexington, KY 40503-0086; 606/233-5161.

## JUNE

**13-15 — 36th Great Smoky Mountains Pediatric Seminar,** Park Vista Hotel, Gatlinburg, TN. Contact: The University of Tennessee Department of CME, 1924 Alcoa Hwy, D-116, Knoxville, TN 37920; 615/544-9190.

**17-21 — Thirteenth Family Medicine Review,** Hyatt Regency Hotel, Louisville, KY. Contact: Laura Tucker, CME, University of Louisville, Louisville, KY 40292; 502/588-5329.

**21-23 — Focus on the Chronically Ill Patient,** Sandestin Beach Hilton, Destin, FL. Contact: LaDonna Nail, Southern Medical Association, 35 Lakeshore Dr, Birmingham, AL 35219-0088; 1/800/423-4992; 205/945-1840.

## JULY

**20-27 — 9th Annual Medical Seminar at Plummer's Great Slave Lake Lodge,** Northwest Territories, Canada. Sponsored by North Memorial Medical Center, University of Minnesota Department of Family Practice and St John's Regional Health Center, Springfield, MO. Contact: 612/588-9478.

## OCTOBER

**27-November 1 — Twenty-Second Family Medicine Review — Session III;** Hyatt Regency Hotel, Lexington, KY. Contact: Ms Joy Green, Director CME, 132 College of Medicine Office Bldg, U of K, Lexington, KY 40503-0086; 606/233-5161.



# "Okay, so I know I need iron. Where do I get it?"

Faced with a Recommended Daily Dietary Allowance of 15 mg, the question is a good one for women aged 19-50. Iron is one of the nutrients most often lacking in the American diet. Low intakes of iron over prolonged time can lead to iron deficiency anemia.

In the 1986 USDA Continuing Survey of Food Intakes by Individuals<sup>1</sup>, women of childbearing years reported a mean intake of 1588 calories a day. Since the American diet averages about 6-7 mg iron per 1000 calories, it's not surprising that the same survey found that most of these women are getting about 60 percent of their RDA for iron.

Yet consider, one three-ounce serving of lean sirloin contains 2.8 mg of iron, about forty to sixty percent of which is heme iron, the most bioavailable form. In addition, the presence of beef or other meats in a meal increase the bio-availability of nonheme iron from foods such as vegetables and grains.

Importantly, lean beef can also meet fat and cholesterol guidelines of most leading heart and health authorities. The how-to's are good advice for almost anyone.

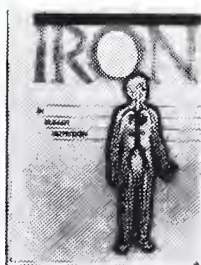
Start with "The Skinniest Six" shown below. None is more than 180 calories per three-

ounce cooked, trimmed serving. All are easy to specify at the meat counter.

These six cuts also simplify portion control. Four ounces uncooked equals about three ounces cooked. Grilling, broiling and roasting add no extra fat in cooking. And the taste of beef makes it easy to dispense with fat-laden sauces.

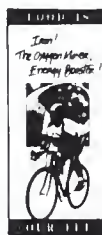
Carefully chosen, prepared and served, "The Skinniest Six" provide an impressive list of essential nutrients for under 180 calories per three-ounce serving.

And as part of a specific plan to increase dietary iron, in a balanced diet, beef can be one of the best-tasting recommendations you'll ever make. For more information on how beef fits a healthy diet, return the form below.



## Iron in Human Nutrition

A detailed presentation of the forms and functions of iron, factors influencing iron absorption and nutritional requirements. A method for calculating iron availability is presented along with a complete list of iron sources. This booklet was designed for nutrition and health professionals.



## Iron! The Oxygen Mover, Energy Booster!

Tips on energy and iron needs, including quotes from sports medicine health professionals. Recipes with nutrient data are provided along with a nutrient dense menu that suggests ways to use many of the guidelines from the brochure in a daily diet.

### "The Skinniest Six"\*



**Eye of Round**  
1.65 mg iron  
155 calories  
5.5 g total fat  
(2.1 g saturated fat)  
59 mg cholesterol



**Round Tip**  
2.50 mg iron  
162 calories  
6.4 g total fat  
(2.3 g saturated fat)  
69 mg cholesterol



**Top Loin**  
2.10 mg iron  
172 calories  
7.6 g total fat  
(3.0 g saturated fat)  
65 mg cholesterol



**Top Round**  
2.45 mg iron  
162 calories  
5.3 g total fat  
(1.8 g saturated fat)  
72 mg cholesterol



**Sirloin**  
2.85 mg iron  
177 calories  
7.4 g total fat  
(3.0 g saturated fat)  
76 mg cholesterol



**Tenderloin**  
3.05 mg iron  
174 calories  
7.9 g total fat  
(3.1 g saturated fat)  
72 mg cholesterol

*Uncooked whole cuts are shown for purpose of identification.*

United States Department of Agriculture, "Nationwide Food Consumption Survey, Continuing Survey of Food Intakes by Individuals (NPCS, CSFII)" Report No. 86-1.

\* Nutrients in 3 oz. trimmed and cooked: USDA Handbook 8-13, Rev 1986

Please send a sample of:

\_\_\_\_\_ Iron in Human Nutrition

\_\_\_\_\_ Iron! The Oxygen Mover, Energy Booster!

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Mail to: Kentucky Beef Cattle Association**  
733 Red Mile Rd., Lexington, KY 40504



## RURAL KENTUCKY MEDICAL SCHOLARSHIP FUND

The Rural Kentucky Medical Scholarship Fund is accepting applications from residents of Kentucky, who have been accepted at the University of Kentucky College of Medicine or the University of Louisville Medical School. The Fund offers a \$10,000 loan for each year of medical school to a qualified recipient who is willing to practice and reside in a rural county in Kentucky for one year for each loan received. The interest rate is determined on May 1. Repayment options include low interest rates for recipients practicing in rural areas and loan forgiveness for those practicing in areas of the state with critical needs. The Fund is the oldest and most successful of its kind in the nation. The Rural Kentucky Medical Scholarship Fund has loaned approximately \$3 million to over 500 medical students. The deadline date for filing an application is **April 1**. Those interested in applying for a scholarship loan should contact the RKMSF Office at the Kentucky Medical Association Headquarters, 3532 Ephraim McDowell Dr, Louisville, KY 40205, or call 502/459-9790.

# Reflections on the Ancient Mayans of the Yucatan Peninsula

The Mayan Civilization of the Yucatan Peninsula, whose descendants still populate this portion of Mexico, was clearly an advanced and distinguished culture. However, much of the information about their ways of life and beliefs was either lost or intentionally destroyed, making no complete understanding of their culture possible. To the contemporary mind, profound dichotomies existed among their belief systems and their ways of life which further prod curiosity. This is particularly evident in consideration of those of their practices which today would fall under the auspices of science or medicine.

For example, during the Classic period of Mayan civilization, from approximately 200 AD to 900 AD, the study and recording of time was executed to a degree unequaled by any other culture prior to that time. In fact, it was not until the 1900s that the solar year was determined to a degree more exact than the Mayan's determination of 365.2422 days. They further demonstrated their precise observations and calculations by building temples which functioned as astronomical clocks. In one instance, for example, the shadow of a snake weaving up a temple's steps develops to signal the moment of the summer equinox. But while the exactness of their astronomical calculations is staggering when one considers the instruments used for measuring, the motivation for their careful observations of natural phenomena was fear: avoidance of the mythological disasters they felt would befall them if they failed to avoid proscribed time periods, or moments

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***“The practice of medicine was the practice of invocational ‘cures’ conducted jointly by Mayan ‘doctors,’ Shamans, and priests at the appropriate temple for the god appropriate to the specific problem. A book of invocational ‘cures’ has been found, but has thus far eluded translation . . .”***

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of astronomical events considered to harbor bad luck. Their lives were totally and precisely ruled by the solar calendar and the religious and mythological beliefs they attached to various combinations of days, time, or juxtapositions of planets or other heavenly bodies. While their powers of observation and their technical ability to construct architectural monuments which revealed certain astronomical events was essentially unequaled in precision, they did not make the transition from mythologic to scientific thought which accompanied this quality of objective observation of natural phenomena in other cultures.

This dichotomy was evident in their practice of medicine as well. All major occurrences in life were attributed to specific Mayan gods. There is a preponderance of Mayan gods associated with time. Each day is deified and every aspect of time or changes in time is similarly deified. While the moon goddess, IxChel, was the major Mayan deity of medicine, there were many other Mayan deities charged with specific problems in medicine such as development of fever or the curing of certain diseases, death, or the returning of life to the dead. Among other things, IxChel was charged with overseeing childbirth, procreation, and fertility. So it was that the Mayans believed that women going out of doors during an eclipse would bear deformed children, since an eclipse was felt to be a literal attack of the sun on the moon and she was the moon goddess charged with overseeing childbirth. To prevent problems in childbirth one placed an image of IxChel under one's bed during the process.

The practice of medicine was the practice of invocational “cures” conducted jointly by Mayan “doctors,” Shamans, and priests at the appropriate temple for the god appropriate to the specific problem. A book of invocational “cures” has been found, but has thus far eluded translation as the symbols are particularly complex and many of the documents which would have permitted their translation were burned by the Spanish when they first discovered the Mayan culture. It is known that pilgrimages were made to the temples where invocations were performed and the ceremonies were



concluded by dancing, rewrapping of bundles of herbs, and separating the men and women into different groups for "drunken banquets."

Interestingly, to this day, residents of the Yucatan still spurn western medicine in the few areas where such physicians are available to them. Even those who live in relatively developed and civilized centers such as the city of Merida will not uncommonly seek out individuals whom they refer to as "witch doctors" or "herbalists." These individuals are felt to be able to provide a sacred and mystical combination of healing material formed from both animal and vegetable materials gathered from the highly upheld, life-giving, fecund earth, a successor of the ancient Mayan "bundles" used in invocational cures.

This culture mysteriously disappeared sometime between 900 and 1200 AD. The vast urban centers they built and occupied were abandoned without a clue left behind. No archeological evidence has been found to support a military theory for their abandonment. While foreign

peoples and cultures were introduced during that time, which may have disrupted the very precariously balanced Mayan system of social stratification and intra-urban communication, no evidence exists to suggest a fatal introduction of disease. The water table in this dense jungle does fluctuate dramatically and may have declined so greatly as to have prevented continued life in these landlocked jungle urban centers. But to date, there simply are no answers.

Current Mayan descendants still value flattened brows and crossed eyes, but no longer place boards on their infants' heads or dangle stones in front of their eyes to achieve this. The magnificent structures which evidence existence of this sophisticated culture remain, but are literally buried in deep jungle where they appear to be mounds and hills. But delicate threads of medical beliefs and practices exist linking current dwellers in the Yucatan Peninsula to this time in their history.

**Martha Keeney Heyburn, MD**

## *Interprofessional Code*

# Kentucky Medical Association and Kentucky Bar Association

### *Preamble*

Revised October 16, 1984

### **General Principles**

**D**octors of medicine and attorneys at law, as members of two professions possessing a close personal relationship with those they serve, have established principles of ethics applicable to the traditions and requirements of their respective callings.

The physician has responsibility for the care of the individual, in health as in disease. He must minister to his patient's needs to the best of his ability and in accordance with the high precepts of the Hippocratic Oath.

The attorney is an officer of the court, sworn to support the Constitution of the United States and of the state or states in which he is admitted to practice. As is the physician, he also is pledged to maintain the confidence and to preserve inviolate the secrets of his clients. He will not reject, from any consideration personal to himself, the cause of the defenseless or oppressed, nor delay any man's cause for lucre or malice.

The attorney represents his client as advisor and confidant, as his advocate in legal proceedings and as negotiator in the business and personal affairs of his client. The physician's relationship is parallel, for he is also the advisor and confidant of his patient in matters of health.

### **Interprofessional Relations**

Each profession is obligated by its own stature to respect and honor the calling of the other. Neither the fact nor the appearance of incompetence, corrup-

tion, dishonesty, or unethical conduct on the part of individual members of either profession can be tolerated. It follows then that each profession must vigorously support within its own ranks, as well as in the ranks of the other, those ethical concepts which each has found necessary in the public good. One who has chosen to be a physician or an attorney and has been found competent to be such by appropriate authorities, is vested with high responsibilities and privileges to enable him to serve the public with honor, with dignity, and with effectiveness.

### **This Code**

A statement of ethical principles states a guide to the attainment of the best in interprofessional conduct and practices. IT IS NOT NECESSARILY OF A BINDING CHARACTER, NOR CAN IT BE SO DETAILED TO COVER EVERY CIRCUMSTANCE.

This Interprofessional Code constitutes the further recognition that with the great developments in the science and art of both medicine and law, it is inevitable that the physician and the attorney are drawn into steadily increasing association, as the law calls with increasing frequency upon medicine for its scientific knowledge and for its evaluation of facts so that the rights of individuals and of the government may be appropriately determined before various tribunals.

### **I. RECIPROCAL DUTIES**

#### **A. The Attending Physician and His Patient**

The medical profession affirms the obligation of a patient's attending physician to cooperate willingly with the patient's attorney in supplying facts, primarily available only to him. The physician should accept the further responsibility of explaining such facts in such a manner that the attorney understands them and can determine their relationship to his client's cause. There should be complete cooperation between the physician and the attorney, each assuming his proper responsibility.

It is for the physician to determine the actuality or probability of fact pertaining to his patient's medical condition. It is for the attorney to determine how and under what circumstances such facts are to be appropriately presented.

A physician should never advise on the amount of damages a patient should seek to recover. The proper province of his professional advice is the extent, degree, or percentage of illness, injury, disability, or similar judgments based upon his professional knowledge of the case. He is not expected to understand technical rules of legal liability, or evidence, or of trial techniques. The latter are the exclusive province of the attorney.

#### **B. The Attorney and His Client**



## Interprofessional Code

It is a part of the attorney's oath on his admission to the bar of this state that he will not counsel or maintain any suit or proceeding which shall appear to him to be unjust, or any defense, except such as he believes to be honestly debatable under the law of the land. He will employ, for the purpose of maintaining the causes confided to him, such means only as are consistent with truth and honor and will never seek to mislead the judge or jury by any artifice or false statement of law or fact.

In discharge of that oath, it becomes the attorney's responsibility to marshal the facts and to obtain professional and other opinion which, in his judgment, are necessary for his client's case and in a manner consistent with his oath and the ethics of his profession.

It is important that the physician understand that legal proceedings in this country are conducted under what is known as the "adversary system." Under that system the attorney occupies a dual position. He is not alone an officer of the court. He is also the single-minded advocate for his client. He does not and cannot properly represent both sides to a dispute.

This system has developed in recognition of the truth demonstrated countless times that justice can usually be satisfactorily accomplished if the two or more contestants can present their point of view to some neutral third person who can weigh the opposing claims. Such claims are usually presented in the form of testimony which is offered in question and answer form. The judge of a court of the officer presiding before an administrative tribunal is the referee who weighs the opposing points of view and the conflicts in testimony. In a sense the judge or administrative officer much more nearly approximates the physician in objectivity. The physician well knows, however, that in some situations it is also possible for medical men to vary honestly and sincerely in their physical findings, their treatment, and their evaluation of illness or injury. In some types of court cases the parties

prefer to let a group of sworn but interested citizens, the jury, weigh and "find" the facts.

## II. MEDICAL EXAMINATIONS

(Requested by Attorneys or ordered by Court)

### A. General

1. The law provides that a party to a lawsuit may be required to undergo a medical examination by agreement of the opposing attorneys or under a court order.

2. When an appointment is made for the medical examination of a person, the physician sets aside a part of his day for that purpose. It is, therefore, important that attorneys exert their best efforts to insure that such appointments are kept. The attorney for the party to be examined should give explicit instructions to such party that the physician must be notified in ample time should it become impossible for the party to keep the appointment.

### B. Scope of Examination

1. The physician may take a history and perform such examinations as may be advisable in his judgment to formulate an informed opinion regarding the nature and extent of the party's medical condition.

2. Inquiries should not be made by the physician into matters not reasonably related to the legitimate scope of the medical examination.

3. The physician, following his examination, shall reduce to writing a medical report, following the outline set forth in Section III.B.5. herein. The original report shall be forwarded to the court or person requesting the examination, with copies as directed by the court or by the person requesting the examination.

## III. WRITTEN MEDICAL REPORTS

(Prepared for Courts or Attorneys)

### A. The Attorney

1. Requests for reports from a physician should be made in writing as soon

as it is known that the information is needed. The request should be clear as to the specific information desired and the report should be prepared by the physician as promptly as possible.

2. If a report is requested on a physician's patient, the attorney must provide the physician with a written authorization from the patient.

### B. The Physician

1. **Medical Records.** The physician must keep records adequate to supply a patient's attorney all pertinent information regarding the patient-client's medical history.

2. Requests for medical reports should be honored promptly. Undue delays in providing medical reports of bills bearing on a patient's legal rights may prejudice his case.

3. If a physician is unable to make a complete medical evaluation within the time required, he should notify the attorney. In this event, a preliminary report clearly designated as such may serve the attorney's needs until a complete evaluation can be rendered.

4. **Patient's Authorization.** **The physician must have his patient's written authorization before releasing any report or test concerning the patient. Such authorization is not necessary when the person examined is not a patient of the physician, and the examination is made in connection with a legal claim.**

5. **Content of Report.** The following, where applicable, should be included in the report:

a. Time, date and place of first visit.  
b. Accurate history of the injury or medical condition, including pre-existing disease or prior injury.

c. Nature of examination and findings.

d. Results of laboratory work, x-rays, and consultations.

e. Opinion including, where possible, diagnosis and prognosis. **Upon request**, the opinion should also evaluate future physical impairment, necessity for future treatment or surgery, the effect of aggravation of any pre-existing

disease or prior injury, and length of convalescence. The opinion should likewise include the physician's true opinion on the cause of the patient's condition, and the strength of his opinion in evaluating the cause. In this regard, he should consider and state all objective and subjective matters bearing on this opinion, including, where appropriate, his evaluation of the patient's candor when considered in the light of his own medical knowledge.

f. State if patient's condition is stationary, or if the patient is discharged.

g. Subsequent examination: Include complaints and evaluation of condition, nature of treatment, confinement to hospital or home, referrals to other physicians, patient's progress, results of x-rays, ECGs, EEGs, laboratory work and consultations, and a concluding diagnosis and prognosis (see Item e, above).

h. Enclose separately an itemized statement of medical expense to date. Omit charges for medical reports or attorney consultations or ANY REFERENCE TO INSURANCE.

i. Include estimate of cost of future medical care.

#### IV. CONFERENCES

The physician and the attorney should confer relative to the common problems presented in a particular case. Such conferences should be arranged well in advance of court or other hearing at the mutual convenience of each, in full appreciation that to each profession, time is of the utmost importance. No physician and no attorney should be required to spend unnecessary time in arranging or attending such a conference. The attorney who knows and understands the progress of his client's case, the conflict, if any, of its medical aspects and the probability of settlement or trial should determine the necessity of a conference.

**It is unfair to the patient-client, the physician, and the cause of justice to present a medical witness who has not first conferred with the attorney**

**and who, therefore, may lack a full appreciation of the significance to the case of the particular evidence he is being asked to give. It is equally obvious that the attorney is less able to represent the full interest of his client where he has not had the advantage of full conferences with the physician in advance of presenting the case.**

#### V. DEPOSITIONS AND/OR COURT APPEARANCE

Our system of justice depends on being able to require any citizen's time at a judicial proceeding and to give testimony regarding the case. A conference should be held between the physician and the attorney proposing to call him as a witness at some time mutually convenient before the physician is to testify.

##### A. Court Testimony

Both parties recognize that when it has been determined that the just and proper effect of a physician's testimony cannot be obtained without an oral examination in court, there is a necessity for the dissemination of information of both professions concerning the time problems involved in court testimony. The Medical Association recognizes that the legal profession faces calendar problems, which include the uncertainty of dates in a fluid trial calendar. The Bar Association likewise recognizes that the physicians appointments are made in advance and that physicians are in addition faced with pressing medical problems which sometimes cannot be deferred.

##### 1. Attorney's Duties:

a. The attorney should ascertain whether the physician will be available for a trial term prior to the date assigned for trial at that term. He should not order the attendance of a physician as witness unless necessary and in any case without prior notice and conference concerning the matters as to which he is to be interrogated unless both the attorney and the physician agree that such conference is unnecessary.

b. The attorney should write to the physician immediately following the

docket call to advise the physician of the proposed trial date.

c. **The attorney should keep the physician's office advised of the status of the docket and notify the physician as soon as possible prior to trial of the probable trial date.**

d. **In the event of settlement or postponement, the physician should be immediately notified of that fact.**

e. The attorney should give the physician as much notice as possible of the time when his attendance in court is desired. Physicians should not be asked to appear until the attorney is reasonably certain that they will not have to remain at the courthouse more than a short period of time before being allowed to testify. When the physician enters the court room, he shall, through a court attendant, make his presence known to the attorney trying the case. The attorney shall endeavor to put the physician on the stand as soon as possible after his arrival in the court room subject to orderly and proper presentation of the case.

##### 2. Physician's Duties:

a. The physician has a moral and ethical obligation to give testimony regarding his patient. If the physician undertakes the care of a patient and litigation ensues, the physician should recognize his responsibility to testify as to the medical condition of that patient, subject to the provisions of the Agreement.

b. When given adequate notice of the time when he will be called upon to testify, the physician should make himself available at that time, unless an emergency situation arises which precludes his appearance.

##### B. Depositions

##### 1. Physician-Patient Privilege.

Where testimony is given and documents are called for by counsel during the taking of depositions in personal injury lawsuits, the usual obligation of confidence in the physician-patient relationship does not exist, and physicians shall furnish any and all pertinent documents, reports, records, notes or



## Interprofessional Code

x-rays regarding the patient which are requested by counsel for either party to the lawsuit.

2. **Deposition Defined.** A deposition is an official proceeding authorized by law whereby a physician may be required to give testimony and be cross-examined under oath outside of court before a court reporter who is a notary public and in the presence of attorneys representing the parties. He may be requested to produce pertinent medical records at the deposition hearing. He may also be requested to release the records, x-rays, ECGs, EEGs, etc to the notary public for duplication and return.

3. **Time and Place.** The time and place of the deposition should be set **by agreement** with the physician. Unless there is a compelling reason to the contrary, it should be taken at the physician's office **at the time agreed, keeping in mind that an attorney's time has the same value as a physician's.**

4. **Subpoenas — Medical Records.** Production of pertinent medical records may also be required by subpoena duces tecum served on the physician. That subpoena requires the physician to attend the deposition at the time and place stated in the subpoena, and there to produce the specified records.

5. **If Attendance at Deposition a Hardship.** If the time and place described in the subpoena for the deposition creates a hardship, the physician should immediately bring this fact to the attention of counsel taking the deposition.

#### 6. Preparation and Deportment

a. The Physician. Since the testimony given at deposition hearings may be read at the trial, it is important that the physician prior to deposition prepare himself as for trial and that his attitude and deportment at the deposition hearing be similar to that at trial.

b. The Attorney. An attorney should totally prepare his case from the medical-legal standpoint so that with a careful use of words he can reduce the area of misunderstanding. It is not proper for

an attorney to seek to color the professional opinion of the physician. No attorney is justified in abusing, badgering or brow-beating any witness, including a physician.

7. **Familiarity with Records.** The physician and the attorney should be thoroughly familiar with their own records and with other related records, including hospital charts and records, at the time the deposition is taken and should have as many of the records at the time the deposition is taken as is possible so that they may be referred to as needed.

8. **Predeposition Conference.** It is to be understood that it is proper to have a predeposition conference between the attorney for the patient and the physician to facilitate the taking of the deposition.

NOTE: If court testimony or a deposition of a physician cannot be set by agreement, the physician's attendance can be required by appropriate legal process. If any doubt arises as to the effect of such legal process, the physician should consult his attorney. A physician should not take offense at being served with a subpoena in the event an agreement cannot be made.

### VI. COMPENSATION FOR MEDICAL REPORTS, DEPOSITIONS, COURT APPEARANCE AND OTHER SERVICES

It is impractical to establish precise rules governing a physician's fees for medical reports, reviewing medical records, conferences, opinions, depositions, court appearances, copies of medical records and other services. It is important, however, that fees be reasonable and that they be discussed in advance by the physician and the attorney. In this way, the major cause of misunderstanding and dissatisfaction will be eliminated. Generally, the attorney who requests these services of a physician is primarily responsible for prompt payment of the physician's reasonable fees. **Under no circumstances may a phy-**

**sician charge a fee for such services which is contingent upon the result of the lawsuit.**

As a matter of policy an attorney should not request a physician to testify on deposition or in court, nor should he subpoena him, without making arrangements for reasonable compensation. This is not required by law, but is suggested as a matter of fairness and cooperation between the professions. A physician should be compensated for the time spent away from his professional practice, regardless of whether he is used as a witness.

### VII. COMPENSATION FOR MEDICAL TREATMENT TO THE PATIENT

A. The patient, not his attorney, is responsible for paying all bills incurred by the patient for his medical care. While bills should be sent to the attorney on the attorney's request, this does not make the attorney responsible for their payment.

B. When the attorney first obtains a written authorization from his client for the release of medical information, the attorney should request his client to authorize the attorney to take out of the proceeds of any recovery by way of settlement or verdict the funds necessary to pay the physician's then outstanding bill for medical treatment. Upon such authorization being given, the attorney should so inform the physician. Upon recovery, if any, the attorney should, in every case, seek to protect the interest of the physician and see that the physician's bill is paid. In the event there is no recovery, or the recovery is insufficient to pay the bill, the attorney should so inform the physician.

(For suggested form, see Appendix A)

### VIII. IMPLEMENTATION OF THE CODE

The purpose of this Code is to establish, maintain and perpetuate a greater degree of understanding and ethics between the respective medical and legal

professions. Any abuse of this Code or violations thereof by a member of either profession should be brought to the attention of the Physician-Attorney Liaison Committee for a determination to be made as expeditiously as possible.

Notice of the nature and pendency of the complaint shall be given to the person about whom the complaint is made.

### IX. AMENDMENTS

This Code may be amended from time to time upon joint resolution of the respective associations represented herein.

This code was originally implemented by a joint committee of the Kentucky Bar Association and the Kentucky Medical Association in 1973.

The revised Interprofessional code was approved in 1984 by the KMA House of Delegates and the Board of Governors of the Kentucky Bar Association.

### APPENDIX A AGREEMENT TO PAY PHYSICIAN FEES

I, \_\_\_\_\_  
hereby authorize and direct my attorney, \_\_\_\_\_, to  
pay promptly to \_\_\_\_\_,  
MD, from my portion of the proceeds  
of any recovery which may be paid  
to me through my attorney as a result  
of the injuries sustained by me (and  
\_\_\_\_\_), on  
\_\_\_\_\_, 19\_\_\_\_, the  
unpaid balance of any reasonable  
charges for professional services  
rendered by said physician and his  
associates on my behalf, said professional services to include those for  
treatment heretofore or hereafter rendered to the time of the settlement  
or recovery, as well as those for medical reports, consultations, depositions  
and court appearances on my behalf. I understand that this does not relieve me of my personal responsibility for all such charges in the event there is no recovery or if the recovery is insufficient to satisfy such charges.

DATED \_\_\_\_\_

Patient \_\_\_\_\_

APPROVED AND ACCEPTED:

DATED \_\_\_\_\_

Attorney \_\_\_\_\_



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# Memoir of John C. Quertermous 1917-1991

by Robert G. Cox  
Executive Editor



Dr John C. Quertermous was born in Livingston County, Kentucky, on September 27, 1917. A 1938 graduate of Murray State University and a 1942 graduate of the University of Louisville School of Medicine, he interned in Cincinnati, served in the US Army for 3½ years during World War II, and then took his internal medicine residency at Louisville General Hospital. He opened his practice in Murray on January 9, 1950, and died exactly 41 years later, January 9, 1991.

Medicine was Dr Quertermous's life. He contributed all of his talents to the profession, and enjoyed it immensely. A past president of Calloway County Medical Society, he served the Kentucky Medical Association in many important capacities over his career. For 13 years, he was a member of the KMA Board of Trustees and a Delegate to the American Medical Association. Dr Quertermous was President of KMA in 1970-71.

Dr Quertermous had a keen interest in politics and a special knack for understanding the political process. He served as Chairman of KMA's Committee on Legislative Activities for National Affairs, and was one of the first Chairmen of the Kentucky Educational Medical Political Action Committee (KEMPAC) Board of Directors. This trait, his medical expertise, and his willingness to serve others led several Kentucky Governors to appoint him to commissions and councils, including the Governor's Citizens Commission on the Problems of the Aging in 1960-61. He was also appointed to the Kentucky Board of Medical Licensure from 1972 to 1986, and served as its President for 7½ years.

For his lifelong contributions to the

profession and to his community, Dr Quertermous received KMA's highest award, the Distinguished Service Award, in 1978. His community activities included terms as President of the Rotary Club, and the Murray Country Club where he fulfilled his avid golfer dreams. He was a member of the Murray Masonic Lodge 105, the Bank of Murray Board of Directors, and the First Christian Church of Murray.

Dr Quertermous will be long remembered for his commitment to his patients, his community, his family, his profession, and to organized medicine. His ready wit, unmistakable laugh, and enjoyment of life touched all those who knew and loved him. As his minister noted at his funeral, "He left large footprints."

Dr Quertermous is survived by his wife of 50 years, Ella Mae; a son, Dr John R. Quertermous; a daughter, Ellen Q. Beth; and three grandchildren.



# December Board Meeting Highlights



**Top:** KMA Secretary-Treasurer William P. VonderHaar, MD, Louisville, addressed the Board as Chairman Cecil P. Martin, MD, Carrollton, presided at the head of the table. **Center and bottom:** Medical student leaders received AMA Student Outreach awards from Kentucky's Senior Delegate to the AMA, Donald C. Barton, MD, Corbin. Kela Lyons, President, UL KMA-MSS, and Paul McLaughlin, UK Chapter President, were honored for their efforts in recruiting student members.

Convening in a regular session, the KMA Board of Trustees held a two-day meeting on December 12 and 13. Oral reports were given, including those of the President, the Secretary-Treasurer, the Senior Delegate to AMA, the Dean of the University of Kentucky College of Medicine, and representatives of the Board of Medical Licensure, the Kentucky Medical Insurance Company, and Sentinel Medical Review Organization.

A special presentation was made to Joe A. and Cecil Dulin Wallace, owners of the Cambus-Kenneth Farm in Danville, in appreciation for their bequeathal of the farm to the Ephraim McDowell Foundation. A plaque was also presented to David W. Kinnaird,





**Immediate Past President Nelson B. Rue, MD, (L) made a special presentation to Joe A. and Cecil Dulin Wallace in appreciation for their bequeathal of the Cambus-Kenneth Farm to the Ephraim McDowell Foundation.**



**L to R: KMA's legal counsel Charles J. Cronan, IV, Esq; President Preston P. Nunnelley, MD; President-Elect S. Randolph Scheen, MD; Past President Nelson B. Rue, MD; and David C. Liebschutz, MD, studied the reports.**



**David W. Kinnaird, MD, Louisville, was honored for his dedication to the McDowell House.**

MD, Louisville, for his dedication to the McDowell House and for his assistance in forming the Foundation.

It was noted that KMA membership had reached an all-time high of 3,722 Active members, and 5,600 members in all categories. William T. Applegate, Executive Director, was congratulated for his installation as President of the Professional Convention Management Association, a position also previously held by KMA EVP Robert G. Cox.

The Board took action on various matters, including submitting the name

of Robert R. Goodin, MD, Louisville, for appointment to the AMA Advisory Committee on Continuing Medical Education of the Council on Medical Education; endorsing guidelines proposed by the Committee on School Health for institutions wishing to conduct sports medicine seminars for high school athletic coaches; and authorizing the implementation of a no-smoking policy in the KMA Headquarters Office.

The Board members also held a lengthy dialogue with representatives of Kentucky Blue Cross and Blue Shield regarding the KMA-endorsed BCBS plan for the membership, and approved terms of the plan renewal, as recommended by the KMA Committee on Medical Insurance and Prepayment Plans. Appointments were made to the KEMPAC Board of Directors; the Journal Editorial Board; and the KMIC Board Election Nominating Committee.

Detailed reports were given concerning the activities of the Committees on National and State Legislative Activities, the Technical Advisory Committee on Physician Services (Title XIX), and the Kentucky Physicians Care Program. It was reported that Kentucky had been chosen for a pilot study on developing new CPT codes for Medicare Billings, and that Board members would be asked to participate by keeping logs for a two-week period.

Legal Counsel reviewed an article regarding "Release of Patient Medical Records," intended to answer questions about the ownership, release, and retention of patients' records, in light of recent court decisions.

The next meeting of the Board was scheduled for April 10-11, 1991. *kma*



# Operation Desert Storm

**T**hrough January 15, KMA has received information that the following physician members have been called to active duty in connection with Operation Desert Storm. If you know of others whose names are not listed, please notify the KMA Office.

William R. Allen  
Richmond

Joe F. Arterberry  
Louisville

Constancio Bautista  
Louisville

Fe Bautista  
Louisville

Ben Bingcang  
Lexington

Eugene Bowling  
Richmond

Richard M. Briggs  
Louisville

Tristan Briones  
Owensboro

Robert E. Broughton  
Madisonville

Frank Buono  
Bowling Green

Andrew G. Bustin  
Frankfort

Aftab A. Chaudhry  
New Albany, IN

William C. Cromwell  
Madisonville

Joseph F. Daugherty  
Florence

Joseph J. Dobner  
Frankfort

Darius Ghazi  
Louisville

Larry P. Griffin  
Louisville

Ralph A. Herms  
Lexington

Richard A. Hoefer, Jr  
Louisville

Marshall R. Johnson  
Elizabethtown

Eusebio C. Kho  
Scottsburg, IN

Andrew T. Kim  
Paducah

Stephen S. Kirzinger  
Louisville

Arthur M. Kunath  
Highland Heights

Peter E. Locken  
Paducah

William Carl Madauss  
Owensboro

Harold V. Markesbery  
Covington

Anthony E. Martin  
Elizabethtown

Willis P. McKee, Jr  
Frankfort

J. William McRoberts  
Lexington

Wally O. Montgomery  
Paducah

Bradford E. Mutchler  
Paducah

William C. Nash  
Elizabethtown

Robert L. Nold  
Louisville

Robert A. Padgett  
Elizabethtown

Billy Joe Parson  
Somerset

James E. Phillips  
Paducah

K. Thomas Reichard  
Louisville

Russell R. Rice  
Louisville

Vivente B. Santelices  
Elizabethtown

John C. Shaw  
Louisville

David L. Speer  
Louisville

Sidney S. Steinberg  
Shelbyville

Thomas R. Taylor  
Elizabethtown

Anne Thompson  
Louisville

David Van Bockel  
Louisville

Charles H. Veurink  
Richmond

John Wright  
Elizabethtown

## Brian E. Brezosky Joins KMA Staff

**B**rian E. Brezosky joined the KMA staff on January 2, 1991, as Director of Governmental Relations. He will serve the Association in various capacities, will assist in KMA's legislative activities, and will staff several committees within the KMA structure.

A native of Louisville, Mr Brezosky earned a Bachelor of Science degree in Police Administration from the University of Louisville in 1982 and a Juris Doctor degree from the University of Louisville School of Law in 1986.

He comes to KMA from the firm of Middleton & Reutlinger where he was in the private practice of law. kma





---

**PEOPLE**

**William T. Applegate** was installed as President of the Professional Convention Management Association (PCMA) at its 35th Annual Meeting in Boston in January. He will serve in this capacity until January 1992.

Mr Applegate joined the Executive Staff of the Kentucky Medical Association in 1968, and has served as KMA's Executive Director since 1978. A graduate of the University of Louisville, he is an active member of several associations including the American Association of Medical Society Executives, the Kentucky Educational Medical Political Action Committee, and an affiliate member of the American Medical Association.

A member of PCMA since 1972, Mr Applegate has taken an active role in the Association as an officer and on numerous committees. He has been a member of the Board of Directors since 1982 and served as President Elect this past year. His installation makes Kentucky the only state with two current staff members who have served in this capacity. KMA Executive Vice President Robert G. Cox was President of PCMA in 1980.

PCMA is an international organization of association meeting professionals dedicated to increasing the effectiveness of meetings and conventions through education and promotion of the meetings industry to its membership, the industry, and to the general public.

The University of Louisville School of Medicine has announced the following appointments to its staff: **John Pank, MD**, assistant clinical professor, anesthesiology; **Jeffrey Sharpe, MD**, clinical instructor, surgery; and **Lynn Simon, MD**, clinical instructor, neurology.

**Emanuel H. Rader, MD**, Pineville, was quoted in an article concerning a managed care plan for Medicaid in the Oct. 15 *Medical Economics*. Under the plan, each Medicaid patient has a primary care physician who coordinates office and emergency room visits, hospital admissions, and Medicaid prescriptions. The physicians receive \$3 a month per Medicaid patient to cover administrative costs. Various versions of this plan are being used in a few states.

Dr Rader says, "Many doctors say they'd like the plan even if they didn't get the \$3 a month, because it gives them a chance to truly manage patients' care. Since patients must get authorization from their assigned doctor before seeing anyone else, we have a much greater awareness of what our patients are doing."

---

**UPDATES**
**US Food and Drug Administration Approval**

The FDA has announced the approval of the first implantable contraceptive for marketing in the US. According to the FDA, the approval was for levonorgestrel implants (the Norplant System), a long-term (up to 5 years), highly effective, reversible contraceptive.

The Norplant System consists of six flexible, closed, tubular capsules, each containing the progestin levonorgestrel. The product does not contain estrogen. The capsules are inserted beneath the skin of the upper arm. The implants should be removed after 5 years and, if desired, new ones inserted at that time.

The FDA reports the following: Successful use and eventual removal of the Norplant System depend on a careful and correct subdermal

insertion of the capsules. Infection and tissue trauma are possible, especially if physicians and other health professionals do not adhere to proper techniques of insertion and removal. The product's distributor, Wyeth-Ayerst Laboratories, is marketing the Norplant System as a kit with detailed instructions in the labeling on insertion and removal. In addition, Wyeth-Ayerst will offer extensive physician training programs. Physicians should not hesitate to remove the contraceptive if a patient requests it.

For further information about the Norplant System and physician training, contact: Wyeth-Ayerst Laboratories, attention: Medical Affairs, PO Box 8299, Philadelphia, PA 19101-1254, or call 1/800/777-6180.

---

**NEW MEMBERS**

*Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.*

**Anderson**

**Patrick A. Sheridan, MD** — IM  
PO Box 511, Lawrenceburg 40342  
1979, Rush Medical College

**Daviess**

**Joseph L. Polio, MD** — ORS  
2816 Veach Rd # 307, Owensboro 42301  
1985, U of Louisville

**Franklin**

**Clarkson T. Palmer, MD** — PM  
338 Westland Dr, Frankfort 40601  
1955, U of Pennsylvania

## Henderson

**John S. Cave, MD** — IM  
3685 Chris Avenue, Henderson 42420  
1987, U of Juarez, Mexico  
**Anthony E. Martin, MD** — GE  
914 N Dixie Ave, #203, Elizabethtown  
42701  
1983, U of Louisville

## Letcher

**Mohamed N. Jabri, MD** — PD  
107 E Main St, Whitesburg 41858  
1983, Aleppo U, Syria

## McCracken

**Sharron D. Butler, MD** — R  
706 Whitney Dr, Paducah 42001  
1983, U of Washington, Seattle  
**Dennis R. Richerson, MD** — AN  
2610 Broadway, Paducah 42001  
1985, U of Kentucky

## Northern Kentucky

**Vincent M. Lubrano, MD** — OBG  
622 Buttermilk Pk, Crescent Springs  
41017  
1985, Texas A & M

## Pike

**Henry W. Gronski, MD** — OTO  
161 Kati St, Pikeville 41501  
1967, U of Washington, Seattle

## Rowan

**Mary S. Phillips, MD** — S  
PO Box 260, Clearfield 40313  
1982, Columbia U

## New In-Training Jefferson

Terry E. Williams, MD — R

## DEATHS

**Dewey L. Bunting, MD**  
Louisville  
1898-1990

Dewey L. Bunting, MD, a retired general practitioner, died December 10, 1990. Dr Bunting was a 1927 graduate of the University of Louisville School of Medicine. He was a member of the CATO Society and a life member of KMA.

**R. Stephen Bowen, MD**  
Mt. Washington  
1924-1990

R. Stephen Bowen, MD, a retired family practitioner, died December 15, 1990. A 1952 graduate of the University of Louisville School of Medicine, Dr Bowen was a life member of KMA.

## KMA Member . . . Auxilian . . .

Our readers are interested in the important events occurring professionally in the lives of their fellow members. Do you, or someone you know, have a newsworthy note to submit for possible publication in your *Journal of the KMA*? If so, please submit in writing to:

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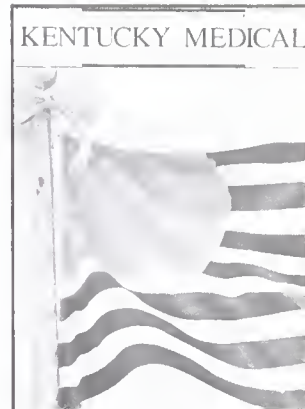
**David C. Liebschutz, MD**  
PO Box 245  
Danville 40422  
(606) 236-7371 1992

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**COVER:** This issue of the Journal is dedicated to our many patients and colleagues serving our country with pride during Operation Desert Storm.

The magnificent illustration of our United States flag is by Louisville illustrator Lee Wade.

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**Description:** Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

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Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

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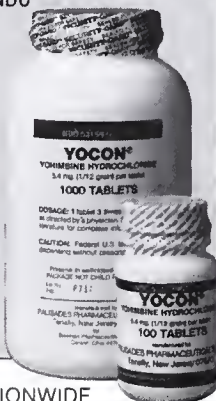
**Dosage and Administration:** Experimental dosage reported in treatment of erectile impotence.<sup>1,3,4</sup> 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.<sup>3</sup>

**How Supplied:** Oral tablets of Yocon<sup>®</sup> 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

#### References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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## This Profession

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***“This ‘profession’ that the previous generation of physicians pronounced dead, we are again burying. But we adapt and mutate and go on.”***

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**W**hen I was asked to write this month's President's Page I was excited. Then I thought, "You don't really want me to do this, I have nothing profound or very scholarly to say. I am just a longtime country doctor. You need a mover and a shaker to write this page." But, maybe once in a while we need to slow the pace a little and reflect.

We have lived through many years of great crisis, but probably none more so than now. We have crisis in our personal lives and our medical lives. As I write this page, Iraq is shaking the gates of hell, and by the time this page is printed, we

will know if the demons have been released on the world. All levels of our government continue to encroach on all of our freedoms and allow minor bureaucrats to usurp our power to associate freely with our patients and provide the best medical care we can.

You have heard similar complaints, warnings, and fears from each generation before us, both from our personal families and our medical families of the past. As an intern, 21 years ago, the practicing physicians would sit around, shake their heads, and sagely say, "I'm glad I'm not you, just starting into practice. Medicine is no fun anymore, there is just too much government interference." Well, 20 years have passed and many of my colleagues are singing the same lament. "I wouldn't go into medicine today; I won't let my children go into medicine. There is too much interference." This comes from men and women who have prospered, fed, clothed, and educated their families from this "profession." This "profession" that the previous generation of physicians pronounced dead, we are again burying. But we adapt and mutate and go on. A new



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***“Become part of organized medicine again. The surest way to have our fears come true is to do nothing.”***

---

generation of physicians will continue, changes will continue, and they too will undoubtedly lament the passing. Certainly, each of these stages is made up of different kinds of people with different life experiences and different goals. The “profession” is being pushed back around the circle toward its beginning status, where we become tradesmen. The majority of our graduates now work for someone else. There will continue to be men and women of good will and spirit expanding the frontiers, but fewer and slower. Progress will slow, allowing the economy to catch up with the cost, allowing us to better allocate the resources we already have. Expectations of the public will stabilize and a new atmosphere will be established where the cycle can start again.

Practicing medicine is still the noblest of “professions,” and will remain so for the foreseeable future. We have been attacked and injured, but continue to fight back. We have been tarnished by the entrepreneurs among us, but not rusted out or rotted from within as the men who established excess medical schools had planned. My patients are still grateful. I still thank each and every one of them for coming to see me and God for the good fortune to be here.

Please don't sit idle with long faces. Get out and get active. Become part of your community again. Become part of organized medicine again. The surest way to have our fears come true is to do nothing.

**Cecil D. Martin, MD**  
**Chairman, Board of Trustees**



# "Okay, so I know I need iron. Where do I get it?"

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In the 1986 USDA Continuing Survey of Food Intakes by Individuals<sup>1</sup>, women of childbearing years reported a mean intake of 1588 calories a day. Since the American diet averages about 6-7 mg iron per 1000 calories, it's not surprising that the same survey found that most of these women are getting about 60 percent of their RDA for iron.

Yet consider, one three-ounce serving of lean sirloin contains 2.8 mg of iron, about forty to sixty percent of which is heme iron, the most bioavailable form. In addition, the presence of beef or other meats in a meal increase the bio-availability of nonheme iron from foods such as vegetables and grains.

Importantly, lean beef can also meet fat and cholesterol guidelines of most leading heart and health authorities. The how-to's are good advice for almost anyone.

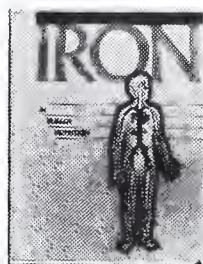
Start with "The Skinniest Six" shown below. None is more than 180 calories per three-

ounce cooked, trimmed serving. All are easy to specify at the meat counter.

These six cuts also simplify portion control. Four ounces uncooked equals about three ounces cooked. Grilling, broiling and roasting add no extra fat in cooking. And the taste of beef makes it easy to dispense with fat-laden sauces.

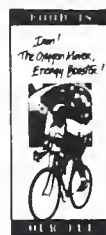
Carefully chosen, prepared and served, "The Skinniest Six" provide an impressive list of essential nutrients for under 180 calories per three-ounce serving.

And as part of a specific plan to increase dietary iron, in a balanced diet, beef can be one of the best-tasting recommendations you'll ever make. For more information on how beef fits a healthy diet, return the form below.



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<b>Eye of Round</b> 1.65 mg iron 155 calories 5.5 g total fat (2.1 g saturated fat) 59 mg cholesterol	<b>Round Tip</b> 2.50 mg iron 162 calories 6.4 g total fat (2.3 g saturated fat) 69 mg cholesterol	<b>Top Loin</b> 2.10 mg iron 172 calories 7.6 g total fat (3.0 g saturated fat) 65 mg cholesterol
		
<b>Top Round</b> 2.45 mg iron 162 calories 5.3 g total fat (1.8 g saturated fat) 72 mg cholesterol	<b>Sirloin</b> 2.85 mg iron 177 calories 7.4 g total fat (3.0 g saturated fat) 76 mg cholesterol	<b>Tenderloin</b> 3.05 mg iron 174 calories 7.9 g total fat (3.1 g saturated fat) 72 mg cholesterol

*Uncooked whole cuts are shown for purpose of identification.*

<sup>1</sup> United States Department of Agriculture, "Nationwide Food Consumption Survey, Continuing Survey of Food Intakes by Individuals (NFIIS, CSFII)" Report No. 86-1.

\* Nutrients in 3 oz. trimmed and cooked: USDA Handbook 8-13, Rev 1986

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*Am Fam Phys* 1987;36:133-140

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#### Brief Summary.

Consult the package literature for prescribing information. Indication: Lower respiratory infections, including pneumonia, caused by *Streptococcus pneumoniae*, *Haemophilus influenzae*, and *Streptococcus pyogenes* (group A  $\beta$ -hemolytic streptococci).

Contraindication: Known allergy to cephalosporins.

Warnings: CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

#### Precautions:

- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of non-susceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

#### Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:

- Hypersensitivity reactions have been reported in about 1.5% of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions have been reported with the use of Ceclor. These are characterized by findings of erythema multiforme, rashes, and other skin manifestations accompanied by arthritis/arthralgia, with or without fever, and differ from classic serum sickness in that there is infrequently associated lymphadenopathy and proteinuria, no circulating immune complexes, and no evidence to date of sequelae of the reaction. While further investigation is ongoing, serum-sickness-like reactions appear to be due to hypersensitivity and more often occur during or following a second (or subsequent) course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults with an overall occurrence ranging from 1 in 200 (0.5%) in one focused trial to 2 in 8,346 (0.024%) in overall clinical trials (with an incidence in children in clinical trials of 0.055%) to 1 in 38,900 (0.003%) in spontaneous event reports. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy; occasionally these reactions have resulted in hospitalization, usually of short duration (median hospitalization = two to three days, based on postmarketing surveillance studies). In those requiring hospitalization, the symptoms have ranged from mild to severe at the time of admission with more of the severe reactions occurring in children. Antihistamines and glucocorticoids appear to enhance resolution of the signs and symptoms. No serious sequelae have been reported.

- Stevens-Johnson syndrome, toxic epidermal necrolysis,

and anaphylaxis have been reported rarely. Anaphylaxis may be more common in patients with a history of penicillin allergy.

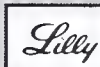
- Gastrointestinal (mostly diarrhea): 2.5%
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
- Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1% and, rarely, thrombocytopenia and reversible interstitial nephritis.

#### Abnormalities in laboratory results of uncertain etiology.

- Slight elevations in hepatic enzymes.
- Transient lymphocytosis, leukopenia, and, rarely, hemolytic anemia and reversible neutropenia.
- Rare reports of increased prothrombin time with or without clinical bleeding in patients receiving Ceclor and Coumadin concomitantly.
- Abnormal urinalysis; elevations in BUN or serum creatinine.
- Positive direct Coombs' test.
- False-positive tests for urinary glucose with Benedict's or Fehling's solution and Clinistix<sup>®</sup> tablets but not with Tes-Tape<sup>®</sup> (glucose enzymatic test strip, Lilly).

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# Continuous Arteriovenous Hemofiltration in the Critically Ill Patient

Ascan Warnholtz; A. David Slater, MD; Thomas A. Golper, MD

*Continuous arteriovenous hemofiltration (CAVH) is a simple extracorporeal treatment for fluid overload, electrolyte imbalances, and removal of uremic toxins. The CAVH technique can be initiated rapidly and allows effective fluid removal without compromising cardiovascular status. This article describes two illustrative cases where CAVH was used to treat fluid overload accompanying in one case cardiogenic shock and in the other case septic shock. CAVH may have contributed to the removal of sepsis-related vasodilators as well as excess fluid. This therapy is an attractive alternative to hemodialysis in the critical care setting and may be the treatment of choice in hemodynamically unstable patients.*

Although the benefits of CAVH in the critically ill patient are well described,<sup>1-5</sup> CAVH is not widely utilized in Kentucky. CAVH requires either temporary femoral arterial and venous catheters or a semipermanent Quinton-Scribner shunt. The cannulae are connected to a hemofilter with a membrane highly permeable to water and non-protein-bound small and middle molecular weight solutes (Fig 1). Systemic blood pressure provides the driving force to achieve sufficient blood flow to the filter. Gentle suction can be applied to the filtrate compartment of the hemofilter to generate a transmembrane pressure that contributes to ultrafiltration of plasma water.

The underlying solute transport mechanism is convection across the filter membrane without osmolar changes in cells or extracellular fluid. This results in rapid replacement of the removed vascular fluid and solutes by cellular fluid and solutes without hypotension. This is in distinction to traditional diffusion dialysis that removes solute osmoles preferentially at first from the vascular space and extracellular fluid. Thus, during dialysis there is a decrease in extracellular osmolarity and cells become hypertonic to extracellular fluid. This results in water movement from the extracellular fluid into cells.<sup>6</sup> Because there

is additional fluid removal across the dialyzer membrane, extracellular and intravascular fluid volume depletion occurs, causing hypotension.

The treatment of critically ill patients often requires the removal of large amounts of fluid in the presence of hemodynamic instability. Since the blood pressure drops concomitantly with increasing fluid removal, hemodialysis is often unsuccessful in this setting.<sup>5</sup>

*From the Department of Medicine, Division of Nephrology (Mr Warnholtz and Dr Golper), and the Department of Surgery, Division of Thoracic Surgery (Dr Slater), University of Louisville School of Medicine, Louisville, Kentucky.*

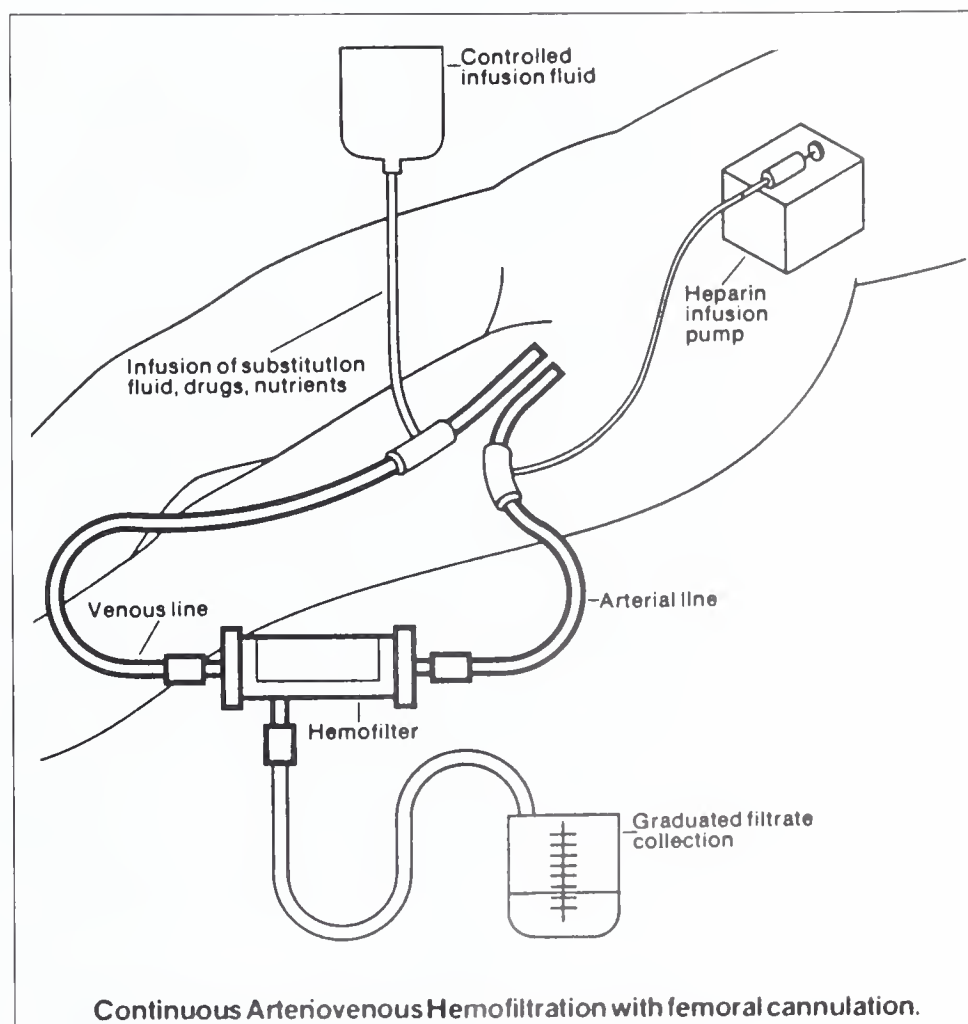


Fig 1



## Arteriovenous Hemofiltration

## Case Reports

## Case 1. (Table 1)

A 50-year-old man was transferred from another hospital in cardiogenic shock secondary to an acute myocardial infarction. He developed a cardiopulmonary arrest during transport and after successful resuscitation, an intra-aortic balloon was inserted. He underwent emergent quadruple coronary bypass grafting. Postoperatively he remained hypotensive and became oliguric, unresponsive to 200 mg of intravenous furosemide. Because of worsening pulmonary edema CAVH was initiated 20 hours postoperatively using femoral artery and femoral venous cannulae. After 7 hours the filter clotted and was changed without difficulty. No further clotting was noted after an increase in his heparin infusion to 1000 units/hour. After 18 hours a net fluid removal of 6.3 liters was achieved with stabilization of blood pressure. Because pulmonary artery and central venous pressures had decreased, the filtration was discontinued. A day later fluid overload recurred and CAVH was reinstituted. A net fluid removal of 4.9 liters was achieved over 24 hours, central pressures declined, and blood pressure remained stable. CAVH was stopped when urinary output became responsive to diuretic therapy. During both periods of filtration serum electrolytes re-

mained stable. Total protein increased and there was transient rise of the BUN and serum creatinine. During the first course the hematocrit was stable, but there was an increase from 26.6 to 41.1 volumes percent in the second course because of the administration of 2 units of packed red cells. After the second treatment the patient remained hemodynamically stable with appropriate fluid balance. The subsequent hospital course was unremarkable and the patient was discharged on hospital day 19 in stable condition.

## Case 2. (Table 2)

A 42-year-old man was admitted with an infection at the site of an automatic implantable cardioverter defibrillator. The device was removed and the site debrided then closed with suction drains. He was stable for 7 days when he suddenly developed hypotension, metabolic acidosis, hyperkalemia, and fever. He was successfully fluid resuscitated but was left with acute fluid overload resistant to diuretic therapy. CAVH was initiated through percutaneously placed femoral arterial and venous cannulae. After several filter changes due to clotting, the filter functioned satisfactorily for 25 hours. During that period systemic and central venous pressures remained stable. The net fluid removal was 3.0 liters with high ultra-

Table 1. Patient No. 1

Parameter		CAVH Course 1			CAVH Course 2		
		Pre-CAVH	Intra-CAVH	Post-CAVH	Pre-CAVH	Intra-CAVH	Post-CAVH
BP	systolic/mmHg	108	101-125	120	126	110-135	131
	diastolic/mmHg	43	39-66	50	53	46-91	86
PAP	systolic/mmHg	42	34-47	35	35	24-37	31
	diastolic/mmHg	25	18-25	18	20	15-23	20
CVP		19	9-20	9	14	7-14	11
Cardiac Output l/min		4		3.76	3.74		3.74
U/F Rate Mean ml/h				443		356	
	Minimum ml/h		50			50	
	Maximum ml/h		1000			1100	
Fluid Balance Mean ml/hr				-350		-206	
	Minimum ml/h		-882			-942	
	Maximum ml/h		68			25	
Total Intake ml			2670/18h			4887/24h	
Total Output ml			8970/18h			9839/24h	
ACT sec			>160			>160	
PTT sec			>60			>52	
Sodium mmol/l		137	133-137	133	128	126-129	128
Potassium mmol/l		3.9	3.9-4.1	4.1	4.0	1.0-4.1	1.1
BUN mg/dl		16	16-28	28	50	48-64	64
Creatinine mg/dl		2.3	2.3-2.5	2.5	2.3	2.2-3.0	3

filtration rates and appropriate replacement fluid administration. The hyperkalemia and acidemia resolved rapidly with administration of sodium bicarbonate infusion as part of the replacement fluid regimen. The BUN rose while serum creatinine was constant. Eventually, adequate anticoagulation was achieved by an initial heparin bolus of 2000 units and maintenance heparin infusion at 550 to 1000 units/hour. The hematocrit increased from 26.6 to 30.7 volumes percent. After 48 hours he became responsive to diuretics, and CAVH was discontinued. The patient recovered steadily and was discharged from the hospital 3 weeks later.

## Discussion

CAVH provides treatment for patients with diuretic resistant fluid overload and hemodynamic instability in acute renal failure, cardiogenic shock, sepsis or post cardiac surgery.<sup>1-5, 7-13</sup> The ultrafiltration rate as well as the replacement fluid administration require hourly monitoring. The ultrafiltration rate is determined by hydrostatic and oncotic pressures. A hydrostatic transmembrane pressure induces ultrafiltration. There are several components to the transmembrane pressure including blood pressure, oncotic pressure, and the suction effect of the water column in the ultrafiltrate drainage line. Thus, arterial blood pressure, blood flow, the blood access device, and the syphon effect of the ultrafiltrate column all contribute to the ultrafiltration rate. The plasma oncotic pressure works against ultrafiltration and is dependent on the total protein concentration within the blood compartment of the hemofilter. The ultrafiltration rate can be adjusted by varying the ultrafiltrate drainage column height. Golper previously reviewed the detailed management of CAVH.<sup>4</sup>

Fluid overload is often a problem in hemodynamically unstable patients. By administering less fluid than the volume of removed ultrafiltrate, a negative fluid balance can be easily established. Since the composition of plasma water and ultrafiltrate are similar, the ideal filter replacement fluid would replace all plasma water constituents except for uremic solutes.

Saline with added calcium, magnesium and bicarbonate are often used.<sup>4</sup> Some authors recommend Ringer's solution.<sup>2,3</sup> The substitution fluid should be adapted to the individual patient's needs. The correction of electrolyte imbalances is achieved by modification of the electrolyte con-

**Table 2.** Patient No. 2

Parameter		Pre-CAVH	Intra-CAVH	Post-CAVH
BP	systolic/mmHg	78	77-124	97
	diastolic/mmHg	50	50-74	60
PAP	systolic/mmHg	51	37-64	47
	diastolic/mmHg	27	20-31	20
CVP		24	20-27	22
Cardiac Output		5.47	3.86-5.97	4.0
U/F Rate	Mean ml/h		835	
	Minimum ml/h		425	
	Maximum ml/h		1100	
Fluid Balance	Mean ml/h		-120	
	Minimum ml/h		-601	
	Maximum ml/h		848	
Total Intake	ml			19680/25h
Total Output	ml			22681/25h
PT	sec		>39.5	
PTT	sec		>82.5	
Sodium	mmol/l	140	133-143	143
Potassium	mmol/l	6.0	3.5-6.0	3.5
BUN	mg/dl	69	69-82	80
Creatinine	mg/dl	2.1	2.1-2.2	2.1

centration in the replacement fluid. CAVH can remove certain electrolytes as rapidly as hemodialysis. Hyperkalemia can be treated as reported in Case 2 with potassium-free replacement fluid and hypertonic sodium bicarbonate infusion.

To enhance solute transport, the CAVH vascular access can be used for traditional hemodialysis, except that no fluid need be removed.<sup>4</sup> One of the major advantages to the use of CAVH is the freedom to administer hyperalimentation fluid. Many critical care patients are severely catabolic and may require up to 5000 ml/day of hyperalimentation fluid. That can be easily managed in CAVH if adequate electrolytes are used in the replacement dextrose-amino acid solution. During CAVH, caloric intake can be increased and a subsequent positive nitrogen balance obtained.<sup>5, 14</sup>

However, hemodialysis is more efficient in removal of urea nitrogen than CAVH.<sup>1, 2, 4, 8</sup> An advantage of CAVH is the continuous nature, in contrast to intermittent dialysis that allows accumulation of uremic toxins between treatments. Urea removal in CAVH becomes more efficient when the ultrafiltration rate is increased. This can be accomplished by increasing the ultrafiltration column height or by using an additional vacuum (suction) pump on the filtrate drainage line.<sup>15</sup>

Both cases reported herein are examples of the broad benefits of CAVH. In Case 1, CAVH was



## Arteriovenous Hemofiltration

successful in a hypotensive patient with diuretic-resistant fluid overload secondary to cardiogenic shock. During both treatment courses the patient was hemodynamically stable despite significant fluid removal. A transient worsening in kidney function was observed, possibly related to the use of the intra-aortic balloon. Filter clotting occurred once in each course, but did not interfere with the efficacy of the treatment. Gerhardt et al have described a rapid decrease in pulmonary capillary wedge pressure after isolated ultrafiltration, associated with an increased colloid osmotic pressure.<sup>9</sup> We may have observed similar findings in patient one. An improved hemodynamic picture has been generally associated with CAVH or similar hemofiltration techniques.<sup>1, 2, 5, 7, 9-13</sup>

In Case 2, fluid overload was associated with hemodynamic instability in septic shock. High ultrafiltration rates allowed administration of larger volumes of replacement fluid. The net fluid removal was modest. Marked cardiovascular dysfunction accompanies septic shock.<sup>16</sup> Bacterial endotoxin and sepsis-related cytokines such as tumor necrosis factor (TNF) are believed to contribute to myocardial depression.<sup>17</sup> We speculate that the removal of TNF may be another benefit of CAVH. However, the pathogenesis of myocardial depression in septic shock is not completely understood.

Complications of CAVH are filter clotting, hemorrhage from the anticoagulation, thrombosis and infection.<sup>4</sup> Hypotension can occur after excessive volume removal without adequate replacement. The expense of CAVH and hemodialysis are approximately equal.<sup>4</sup>

### Conclusion

CAVH has advantages in some cases over hemodialysis or peritoneal dialysis in the unstable critical care patient. It can be easily initiated and gives the physician the ability to regulate the fluid volume, nutrition, and electrolyte status over a continuous period of time.

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# Ophthalmologic Electronic Imaging and Data Transfer

John W. Garden, MD; Charles F. Knapp, PhD; John H. Saunders, MD

*A technique has been developed that allows slit lamp images from a patient in a remote locale to be captured by a computer, with the assistance of a non-ophthalmologist, and transmitted at rapid speeds through telephone lines to an ophthalmologist for visualization of relevant clinical information. The results from this study indicate that (1) eye examinations can be performed at the remote site by non-ophthalmologists; (2) objective data can be transferred to a centralized ophthalmologist for expert interpretation; and (3) decisions can be rendered in areas where medical needs are underserved.*

In 1983, the distribution of ophthalmologic manpower in the United States was addressed and found to be adequate.<sup>1</sup> It was concluded from these studies that only 1% of the population in the US did not have "convenient access to an ophthalmologist." However, it was further noted that certain areas of this country have unmet needs. For example, Kentucky represents one of the states where the shortage and maldistribution of ophthalmologists is a factor. It ranks 48th in services with a ratio of 3.13 ophthalmologists per 100,000 population.<sup>1</sup>

With the ultimate goal of improving ophthalmologic care in underserved areas, we have evaluated an alternative to direct contact between an ophthalmologist and patient. This approach uses electronic image acquisition and transfer, utilizing a non-ophthalmologist, to complete the link between ophthalmologist and patient over large distances.

## Materials and Methods

The image acquisition system (Fig) was composed of a color videophone (VIP produced by Image Data Corporation and distributed by West Coast Data) that was connected to a color TV camera attached to a Slit Lamp (Model 30 SL-M,

Carl Zeiss, Inc). The videophone can send and receive images with up to 16 million colors in approximately 30 seconds with the aid of its data compression scheme. Image resolution is  $592 \times 440$  pixels. Baud rates are self adjusting depending upon the quality of the telephone line. Rates begin at 14.4 kilobaud and decrease until error checking criteria for image transmission accuracy are met. Voice communication between sending and receiving sites is available during the times that images are not being transmitted. Image annotations in the form of arrow cursors appear on both screens to aid identification of regions of interest. The study reported below was conducted at the Federal Correctional Institution, Lexington, KY, and the private practice office of one of the investigators (JWG).

## Results

A total of 21 subjects were examined. Fifteen patients were initially seen by the optometrist at the

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## Ophthalmologic Electronic Imaging and Data Transfer

Table

Lesions	Diagnoses		Correlation
	By Investigator	By Consultant	
<b>Skin</b>			
1.	Adenoma Sebaceum (benign lesion)	Papilloma (benign lesion)	+
2.	Indurated Lesion Possible Basal Cell	Possible Bosal Cell Carcinoma	+
<b>Conjunctiva &amp;/or Sclera</b>			
3.	A. Melonosis B. Nerve Loop	A. Melonosis B. Nerve Loop	+
<b>Cornea</b>			
4.	Foreign Body	Foreign Body	+
5.	Staph Infiltrate	Staph Infiltrate	+
6.	Contact Lens with Flourescein Pattern	Contact Lens with Flourescein Pattern	+
<b>Gonioscopy</b>			
7.	Open angle	Open angle	+
<b>Lens</b>			
8.	Cotaract, direct view	Cataract, direct view	+
9.	Cotaract, direct view	Cataract, direct view	+
10.	Cotaract Retroillumination	Cotaract Retroillumination	+
11.	Cotaract Retroillumination	Cotaract Retroillumination	+
12.	Posterior capsule Opacity, pseudophokos	Posterior capsule Opacity, pseudophokos	+
13.	Posterior Synechioe	Posterior Synechiae	+
<b>Optic Nerve</b>			
14.	Crescent	Crescent	+
15.	Not diagnosed (drusen)	Not diagnosed	+
16.	Gloucomatous Cupping	Glaucomatous Cupping	+
17.	Glaucomatous Cupping	Glaucomatous Cupping	+
<b>Retina</b>			
18.	Not diagnosed (Macular degeneration)	Not diagnosed	+
19.	Macular Degeneration	Macular Degeneration	+
20.	Cryo scor, peripheral	Cryo scar, peripheral	+
<b>Choroid</b>			
21.	Melanotic nevus	Melanotic nevus	+

+ = agreement between investigator and consultant

+ = agreement between investigator and consultant

Federal Correctional Institute. A text overlay containing the history, refraction, visual acuity, intraocular pressure, and the initial interpretation was transferred with a color image of the pathological lesion in question. The stored data was then sent to the office (JWG) in batch files where it was reviewed. If further information was needed, the patient was returned to the slit lamp, and interactive communication using the telephone through the computer system was established. This allowed the consultant to instruct the sender concerning changes of position, magnification,

focus, etc, and then to transmit the new image. Marking arrows were exchanged between screens to identify regions of interest and thereby facilitate the diagnostic procedure. Subsequently, other patients were taken from the office practice to exemplify diverse pathological entities. Gonioscopy was performed with the Goldmann lens and fundus images were gathered with both the Goldmann fundus contact lens and the Volk 90 diopter lens mounted in the articulated holder.

All the anatomic areas accessible by the slit lamp were imaged to present the spectrum of diseases that an ophthalmologist might encounter (Table). The clinical information and color images of the pathology were then interpreted. An independent ophthalmologist rendered a second opinion. Using the matched pairs sign test, there was a significant correlation between the respective diagnoses ( $p > 0.001$ , 1df). In addition, two images clinically identified by the first examiner that were not felt to have sufficient resolution for diagnosis on the monitor were randomly placed in the presentation sequence and received the same interpretation by the second examiner.

## Discussion

The motivation for this study resulted from a request by several regional hospitals in Kentucky that could not supply sufficient ophthalmologic service. The Federal Prison System was chosen as the site for the study because it is composed of a population encumbered by security needs that also makes physician contact difficult.

While technology evaluated in the investigation has been shown to be clinically satisfactory, we do not intend to imply, however, that this approach to medical care will supplant traditional medical services. This approach would be totally unnecessary if it were possible to place a physician in every "hamlet and hollow" in the country. We feel that this approach is a means of data-based decision making to offer a service where it currently does not exist. The equipment in its current state is affordable (ie  $< \$20,000$ ) and cost effective.

It also should be mentioned that, although the technology evaluated in this project was clinically satisfactory in general, two images were deliberately chosen because the resolution was considered inadequate. We feel that the current state of the art will allow us to design equipment of higher resolution that will enable greater clin-

ical acumen to be furnished, if desired. However, as the technology increases so does the expense, and our immediate goal is to meet effective cost/benefit ratios for the supply of medical care.

Ophthalmology is a unique specialty for computer imaging since it is visually intensive. Teleradiology is already utilized and clinical applications such as the approach used here for ophthalmology can readily be applied to pathology, dermatology or any other discipline requiring imaging.

Computers already are present in the management of the business of the practice of medicine in Kentucky. We see this project as an initial venture into data-based remote communication between the practitioners and their consultants. Within the scope of the demographics of the regional hospital system or the geography of regional practices, it would be possible to establish lines of immediate consultation with specialists in private practice in centralized areas or the universities. They, in turn, could respond without delay for the betterment of patient care. Referral considerations, now based on the specialist interpretation of the referring physician's observations, would be enhanced by real data. It is conceivable that many cases could be managed in their home locales, thereby saving the cost of transportation, subsequent specialists fees, and the time lost from work, including friends or family that frequently must accompany the patient. An electronic mail system (E-mail) could link the professions together with better medical care while yielding cost savings.

The authors wish to acknowledge Mr Tom vanCader and Carl Zeiss, Inc who designed and supplied the slit lamp, and Mr Robert Lynch and Mr Roger Gunn with West Coast Data for the imaging equipment. The clinical trials could not have been conducted without the help of Mr Tom Gora, Associate Warden, and Steve Colwell, OD, optometric consultant, at the FCI, Lexington, KY. We also acknowledge the assistance of Dr Robert Baker, Chairman, Department of Ophthalmology, University of Kentucky School of Medicine, who was kind enough to critically review the manuscript.

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# Laser Assisted Balloon Angioplasty in Peripheral Vascular Surgery: A Preliminary Report

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Since Gruntzig and Kumpe introduced the double-lumen balloon catheter in 1974 for transluminal angioplasty,<sup>1</sup> there has been increased acceptance for its use in the treatment of patients with peripheral vascular occlusive disease. The introduction of laser-thermal assisted balloon angioplasty with metal-capped catheters has broadened the scope of these relatively non-invasive approaches. Ginsburg and coworkers; Sanborn and associates; Cumberland et al; Hussein; Fleisher et al; and McCowan have published results of some initial clinical trials.<sup>2-10</sup>

The purpose of this preliminary report is to record our initial experience with laser assisted balloon angioplasty at the Humana Heart Institute International. This experience in 26 patients with 31 lesions has changed our thinking in the management of peripheral vascular disease. We report here: (1) a 77% success rate in short lesions (Fig 1); (2) an early experience with intraoperative angiography; (3) early and persisting patient acceptance of these advanced technologies; (4) the necessity of a three-dimensional concept of occlusiveness (as opposed to two-dimensional interpretations of angiograms); and (5) an early, but thoughtful endorsement of these techniques as primary or adjunctive therapies in the management of early, moderate, and advanced peripheral vascular atherosclerosis.

## Protocol

Our protocol in this clinical trial included the following. All patients had:

1. Complete history and physical examinations.
2. Clinical peripheral vascular evaluations by two physicians.
3. Measurement of ankle/arm index.
4. Angiography of the abdominal aorta and all lower extremity branches.
5. Videotape Laser Angioplasty patient educational conferences.
6. Risk/benefit informed consent.
7. Hematologic coagulation component/profile screening.

Preoperatively, all patients received aspirin

(650 mg) with dipyridamole 75 mg. We prefer epidural anesthesia, but it was accomplished in only 10% of this group. Eighty percent of the procedures were done with spinal anesthesia (our second choice), and 10% received local anesthesia (1% lidocaine infiltration). General anesthesia was never required.

The vascular surgical techniques were standard. All patients received 2500 units of heparin prior to laser angioplasty with an Argon Laser (Trimedyn, Inc, 1815 E Carnegie Ave, Santa Ana, CA 92705). A Siemens (Medical System, 11256 Cornell Park Dr, Suite 500, Cincinnati, OH 45242) digital imaging C-arm unit was used for intraoperative angiography. At the end of the procedure the heparin was partially reversed with protamine sulfate ( $\frac{1}{2} \times$  the heparin dose).

All patients with pre-operative total arterial occlusions were given intravenous heparin infusions post-operatively (500-1000 U/hr.) to increase the partial thromboplastin time to  $1\frac{1}{2}$  times the control level. All patients with pre-operative partial arterial occlusions were given aspirin (650 mg) O.D. and dipyridamole 75 mg T.I.D. One patient received two units of packed red blood cells for hypotension during iliac artery laser angioplasty; there was no evident blood loss or extravasation. No other transfusion was required in this series of procedures. Patients with post-operative hemoglobin concentrations less than 9 gm % were given ferrous sulfate and multivitamins.

## Analysis of Patient Population

All 26 patients were between 60 and 78 years of age (mean 68). Twenty-one were male and 5 were female. Nineteen patients were smokers, 8 were diabetics treated with insulin, 11 were hypertensives being treated, and 2 had mild hypertension requiring no treatment. Eighteen had a history of coronary artery disease, 15 of whom had undergone previous coronary bypass grafting.

All patients were taking aspirin preoperatively on a daily basis. Eight were taking dipyridamole 75 mg two or three times daily, and five

patients were taking antiarthritic medications. None were anticoagulated with Coumadin, but one was admitted with a continuous heparin infusion, which was stopped 2 hours before operation done under local anesthesia.

Twenty-four patients complained of lower extremity intermittent claudication and two had severe rest pain. Twenty-six underwent single or multiple lesion laser angioplasty, and five underwent bilateral iliac, common femoral, or superficial femoral laser angioplasty. All preoperative biochemical analyses were within normal limits except for one patient with chronic renal failure (Creatinine 17.6/BUN 72); the procedure and postoperative course were unaffected in this case.

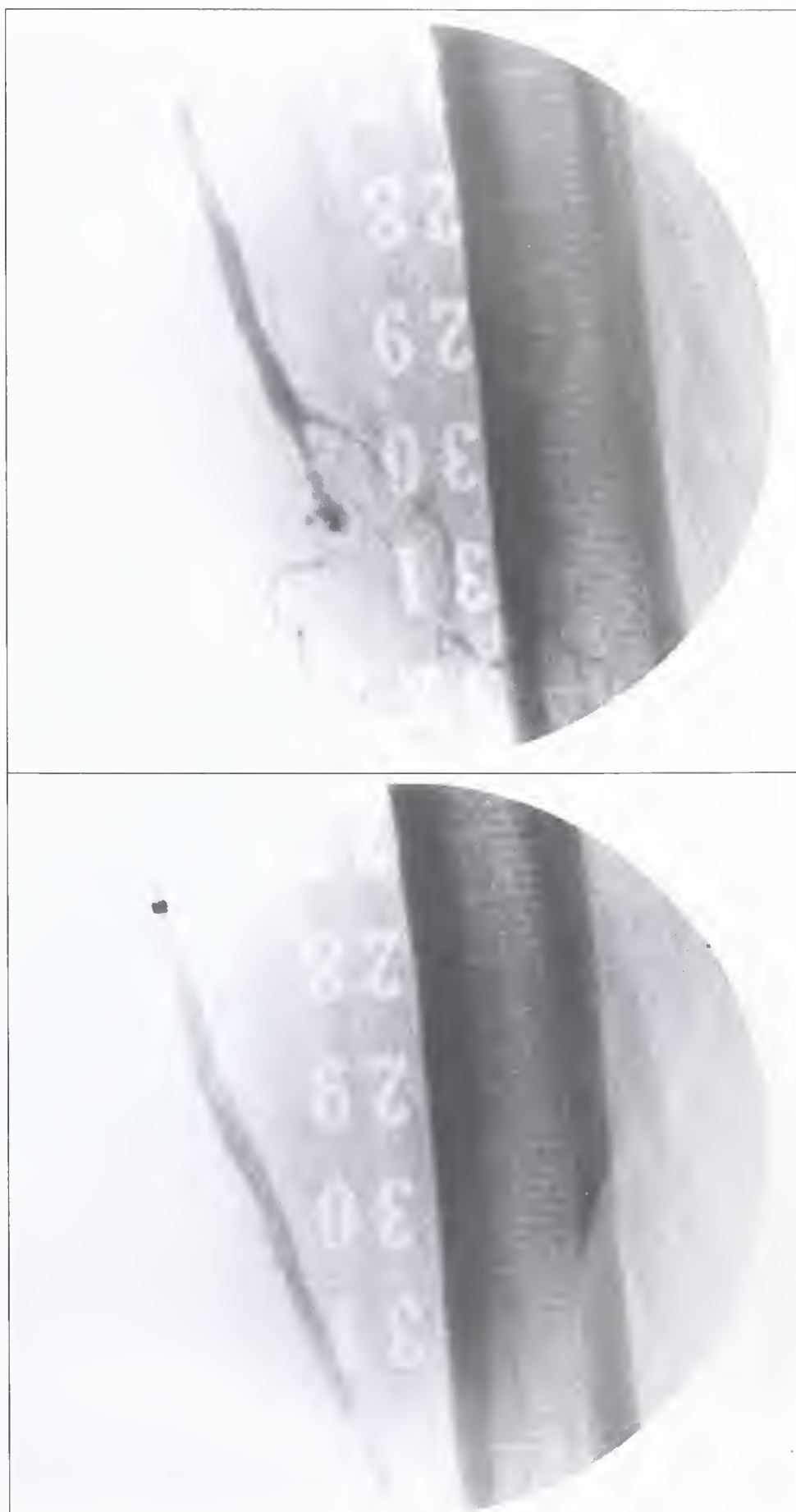
## Methods

In all instances of laser angioplasty, the Argon Laser Unit was used with 2-3 mm probes. For balloon angioplasty, Meditech balloons (Meditech, Inc, 480 Pleasant St, PO Box 7407, Watertown, MA 02272) were used in two patients, Meditech Blue Max balloons in 23 patients, and one Meditech ultrathin was used in a patient with a popliteal lesion. The balloon sizes ranged from 3-8 mm. The laser power utilized varied between 10 and 14 watts, with an exposure time of 20-60 seconds. All intraoperative irrigations were done with heparinized saline (1000 units heparin/1 liter of 0.9% normal saline).

## Intraoperative Observations

All superficial femoral artery balloon dilatations were done at balloon pressures of 11-14 atmospheres. In all, three to five dilatations for 60 seconds were used. Common iliac artery balloon dilatations were done at balloon pressures of 9-11 atmospheres with up to three dilatations, each of 60 seconds. External iliac and popliteal artery balloon dilatations were done with balloon pressures less than 9 atmospheres.

There were two instances of laser unit/probe malfunction; the patients were rescheduled and the procedures undertaken without incident. Of



**Fig 1 — (Upper) Intraoperative angiogram (P.A. view). Right superficial femoral artery totally occluded over a 5 cm length with moderate collateral circulation in a 70-yr-old female with severe one block claudication. (Lower) Right superficial femoral artery after laser-thermal angioplasty with assisted balloon dilation [Argon Trimeddyne 2.5 laser probe with 4 × 6 Blue-Max-Meditech balloon].**



## Laser Assisted Balloon Angioplasty

31 lesions, excessive calcification prevented laser/balloon angioplasty in two instances (one iliac and one superficial femoral). One long superficial femoral artery occlusion (18 cm) required the use of two laser probes for completion.

All results were recorded with intraoperative angiography done with half strength contrast medium during the procedure and full strength for the final image. In selected instances, intraoperative angioscopy was employed with videotaping to good advantage.

All patients had a postoperative decrease of hemoglobin concentration from 0.5-2.0 gms % due to serial flushing of open arteriotomies. None of these patients required transfusion.

### Combined and Staged Procedures

Standard femoral-popliteal or femoral-femoral bypass graft was combined with iliac laser/balloon angioplasty in four patients. Common femoral and profunda artery plastic repair was done in two instances. One patient underwent bilateral, sequential femoral artery laser/balloon angioplasties over a 2-day period.

### Results

Sixteen of the 31 lesions involved the iliac arteries, including three total occlusions, twelve 80% to 90% occlusions, and one 70% occlusion. The longest iliac lesion was 5 cm; the shortest was 8 mm. The success rate of reestablishing a lumen in totally occlusive iliac lesions was 66%. An increase in lumen diameter was achieved in partially occluded iliac arteries in all instances.

There were also 14 femoral lesions in the group. Of these, 6 were total occlusions, 7 were 80-90% occlusions, and 1 was 70% at the femoropopliteal junction. The longest femoral lesion was 18 cm and the shortest was 7 mm. The success rate in reestablishing a lumen in totally occlusive femoral lesions was 83%. An increase in lumen diameter was achieved in partially occluded femoral arteries in all instances.

Ankle/arm indices were improved in 20 of 26 patients, and there was no change in the other six. There was no case of iatrogenic ischemia, renal dysfunction, or embolus. The average postoperative hospital stay was a day and a half. One patient developed right groin cellulitis following conventional femoral-femoral bypass after right iliac thermal-laser angioplasty; this responded to conventional antibiotic therapy. One patient had good pulses following superficial femoral artery laser/balloon angioplasty, but 6 weeks later, distal

pulses decreased and claudication returned. Repeat angiogram revealed reocclusion, and a good result was obtained with standard femoral-popliteal bypass grafting.

### Summary

Laser/balloon thermal angioplasty has proven to be a valuable adjunct in our management of peripheral vascular disease. The initial trials have produced a 77% success rate, a 3% incidence of complications, and no morbidity. Patient acceptance has been high and the return to prior activities in less than 1 week is an appreciated advantage. Laser/balloon angioplasty expands the armamentarium of the vascular surgeon and makes possible broader applications of standard vascular surgical techniques.

We acknowledge the assistance of Mrs Flora W. Johnson, Mrs Betty W. Rainey, Ms Gina Stephenson and Mrs Demetria T. Sturgis.

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# Summary of Actions AMA House of Delegates Interim Meeting

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***In past issues of the Journal, members of the KMA Delegation to the AMA have written articles about specific issues that were discussed by the AMA House of Delegates. So that the membership can be informed on a more timely basis, a summary of the entire meeting is being submitted by the whole Delegation. For more details, please contact the KMA office or any member of the Delegation.***

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**T**he AMA House of Delegates met in Orlando, December 2-5, 1990. This was the busiest House meeting on record with 194 resolutions and 106 Board and Council reports to consider. The House adopted policy on a wide variety of national issues of critical importance to the practicing physician and the American public.

There were 435 delegates seated. The House composition is: 348 delegates representing state medical associations; 77 delegates representing national medical specialty societies; 10 delegates representing medical students, resident physicians, hospital medical staffs, medical schools, young physicians, Army, Air Force, Navy, United States Public Health Service, and the Veterans Administration.

In his Inaugural Address, President C. John Tupper, MD, promised that the "new AMA would be up front, where the action is." Saying that the AMA had kept that promise, Dr Tupper heralded many aggressive actions and new willingness to take risks and "to stand up for our profession in many other ways when the chips were down." Topping his list —

- The AMA's call for the removal of Inspector General Richard Kusserow from his position.
- The success of AMA's Washington Office staff in "looking out for the interest of our patients, in lobbying against government programs and policies that are anti-science and anti-patient."

- The stance of the Council on Ethical and Judicial Affairs on such vital issues as the physician's duty to treat HIV patients, withdrawal of life support, and other public health and public education issues.
- The AMA's leadership role in the development of practice parameters, as a way of improving the quality of care our patients will receive.

The AMA Council on Ethical and Judicial Affairs submitted its opinion related to gifts to physicians from industry and provided guidelines to physicians to avoid the acceptance of inappropriate gifts. In a related report on the Council's opinion, the Council discussed the ethical issues raised by the practice of industry gift giving.

The issue of health insurance companies denying payment for preexisting conditions generated much debate in the Reference Committee. Some spoke to the detrimental impact of coverage of preexisting conditions on the fiscal viability of insurers. Others stressed the need for physicians to serve first and foremost as advocates for their

patients and encourage elimination of preexisting condition limitations.

The delegates heard vehement and unanimous testimony reciting the numerous inappropriate and questionable activities of the Office of Inspector General of HHS, and in support of the AMA's efforts to gain the removal of Mr Kusserow from the position.

Two resolutions dealt with some problems encountered by reserve physicians who have been called to active military service.

OBRA 1990, which was recently signed into law, contains provisions eliminating separate Medicare payment for EKG interpretation. The House agreed to accept an emergency resolution on this issue and took action calling on the AMA to establish a high priority to effect repeal of those provisions included in the law that eliminate Medicare payment in 1992 and beyond for routine reading of EKGs, where the EKG is performed and payment is made to a physician as part of a visit or consultation.

The House approved a thorough and detailed report by the Council on Medical Education that addressed the complex problems of providing health care services and the shortage of physicians in rural areas.

The House received six resolutions about problems associated with the National Practitioner Data Bank. The Reference Committee formulated a substitute resolution which was adopted along with a resolution submitted by the Hospital Medical Staff Section.



The delegates voted to ask the AMA:

- to continue to work with the Department of Health and Human Services to ensure that the National Practitioner Data Bank does not collect nor release information regarding the denial of specific clinical privileges based solely on failure to meet hospital established minimal criteria (ie, level of professional liability coverage, board certification), not related to a physician's competence or professional conduct;
- to continue to work with HHS to revise the current Data Bank dispute process to accelerate a physician's opportunity to attach an explanation or statement to a disputed report;
- to work with HHS to establish an appropriate response time for hospital inquiries to the Data Bank;
- to work with HHS to establish a mechanism to inform physicians when an inquiry to the Data Bank has been made;
- to reaffirm its policy that reports,

other than licensure revocation, in the Data Bank should be purged after 5 years;

- to support efforts to require the same Data Bank reporting requirements for physicians, dentists, and other licensed health care practitioners;
- to reaffirm its policy and use all necessary efforts to direct the National Practitioner Data Bank to send all notifications to physicians by certified mail, return receipt requested;
- to use all necessary efforts at the federal level to direct the National Practitioner Data Bank to begin the 60 day appeal process from the date the physician receives notification.

The Council on Medical Service submitted a report that discusses the PRO Quality Intervention Plan (QIP) and the procedures for PRO notification of quality problems. The Council submitted recommendations that were adopted after modification by the House of Delegates.

The delegates voted to ask the

AMA to urge the Health Care Financing Administration (HCFA) to modify regulations so that (1) in regard to confirmed quality problems which have been *finally* adjudicated by the PRO Quality Assurance Committee, the PRO is required to notify both the physician and president of the hospital medical staff in all such cases, and (2) the PRO be required to implement a mechanism to verify receipt of the PRO's notice of both potential and confirmed quality problems by the physician.

#### **Respectfully submitted:**

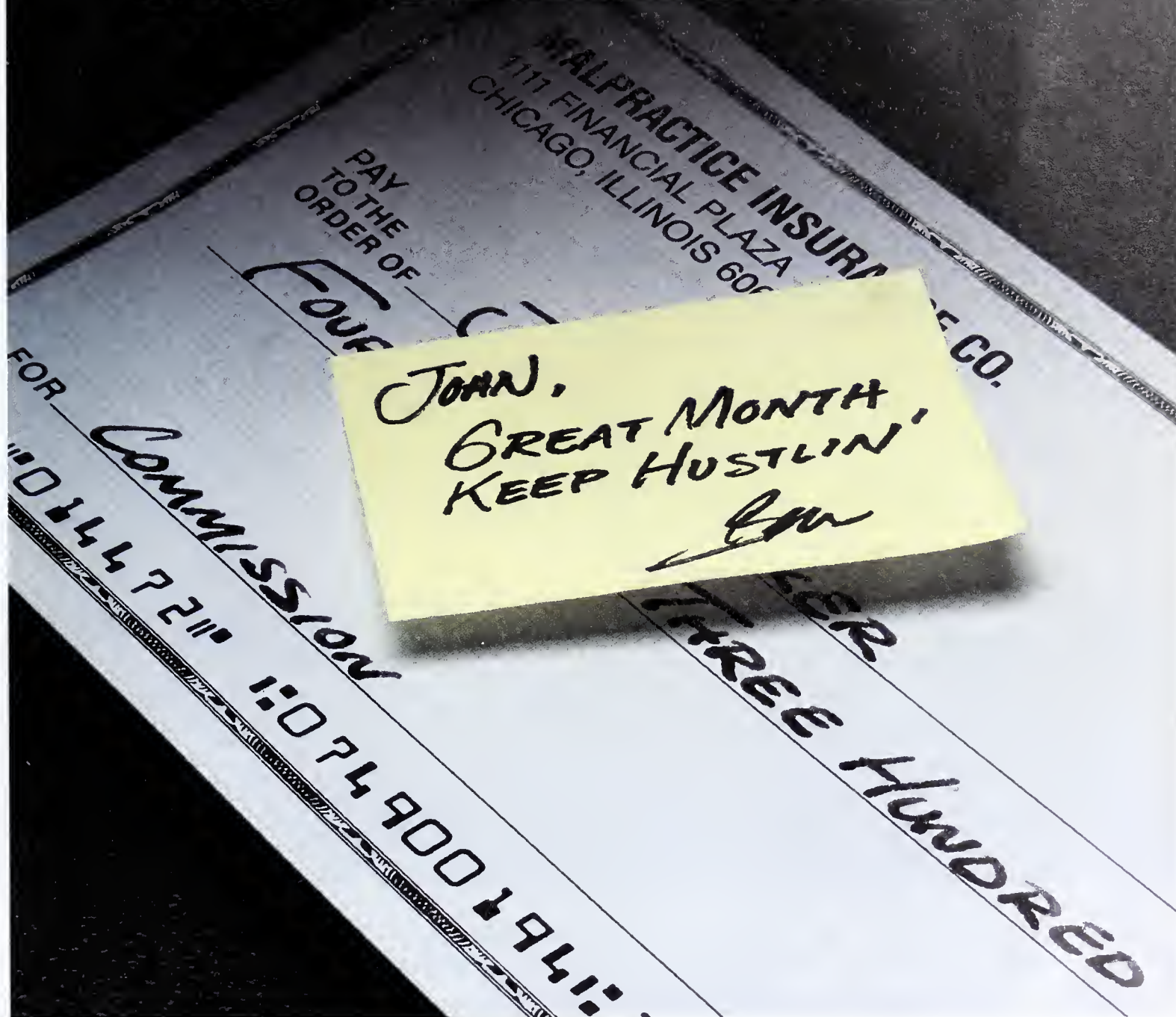
##### *Delegates*

**Donald C. Barton, MD**  
**Kenneth P. Crawford, MD**  
**Wally O. Montgomery, MD**  
**Harold L. Bushey, MD**

##### *Alternate Delegates*

**Robert R. Goodin, MD**  
**Ardis D. Hoven, MD**  
**Donald J. Swikert, MD**  
**Larry C. Franks, MD**

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Session III — October 27-November 1, 1991  
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# AWARDS NOMINATIONS

The KMA Awards Committee is accepting nominations for the two highest awards the Association presents. The Distinguished Service Award is presented annually to a member of the Association based on the following criteria:

- Contributions to organized medicine (including membership in county society, attendance of county and state meetings, service on committees, leadership as an officer, etc.)
- Individual medical service
- Community health, education and civic betterment
- Medical research

The nominee may qualify on any one or all combinations of these points. Reasons for the nominations should be clearly stated.

The Kentucky Medical Association Award is presented to an outstanding lay person in Kentucky each year in honor of his or her outstanding accomplishments in the field of public health and/or medical care.

The Awards Committee will have the responsibility to choose recipients of the KMA Distinguished Service Award and the Kentucky Medical Association Award. Any county society or individual member may suggest nominees to the committee.

The awards are presented at the President's Luncheon during the annual meeting.

## AWARD NOMINATION FORM

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Place: \_\_\_\_\_

Marital Status: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_

Children: \_\_\_\_\_

☐ Distinguished Service Award (Physician)

☐ KMA Award (Lay Person)

Education: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Military: \_\_\_\_\_

Membership in Professional Organizations: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Membership in Civic Organizations: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Honors and Awards: \_\_\_\_\_

(Describe nominees qualifications and other pertinent information which the Awards Committee may consider in making its decision.

Name of Person or Group Submitting Nomination: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: (Home) \_\_\_\_\_

(Office) \_\_\_\_\_

Please fill in and mail to: KMA, Attn: Awards Committee, 3532 Ephraim McDowell Dr, Louisville, KY 40205

Deadline for receiving nominations is July 15.





# Operation Desert Storm

**T**hrough February 13, KMA has received information that the following physician members have been called to military duty in connection with Operation Desert Storm. If you know of others whose names are not listed, please notify the KMA Office.

William R. Allen	Terence J. Hadley	Mellayne R. Myers
Joe F. Arterberry	Amos G. Hall	William C. Nash
Constancio M. Bautista	Ralph A. Herms	Michael S. Nethers
Fe Leano Bautista	Richard A. Hoefer, Jr	William D. Newton
Ben Bingcang	Marshall R. Johnson	Robert L. Nold
Richard M. Briggs	Shawn C. Jones	Robert A. Padgett
Tristan Briones	Gerald E. Kakascik	Billy Joe Parson
Bobby J. Brooks	Eusebio C. Kho	James E. Phillips
Robert E. Broughton	Andrew T. Kim	Russell R. Rice
Frank L. Buono	Stephen S. Kirzinger	Leo F. Rogers
Frank A. Burke	Arthur M. Kunath	Vivente B. Santelices
Andrew G. Bustin	Peter E. Locken	John C. Shaw
Aftab A. Chaudhry	William Carl Madauss	David L. Speer
William C. Cromwell	G. L. Maddiwar	Sidney R. Steinberg
Joseph F. Daugherty	Harold V. Markesbery	Thomas R. Taylor
Joseph M. Dew	Anthony E. Martin	Anne R. Thompson
Joseph J. Dobner	Willis P. McKee, Jr	David A. Vanbockel
Robert J. Emslie	J. William McRoberts	Charles H. Veurink
Darius Ghazi	Wally O. Montgomery	Raymond W. Watters
Larry P. Griffin	Bradford E. Mutchler	John Wright



# Operation Desert Storm — In Honor of



## Outside Looking In!

**T**he hearts of all Americans today are heavy with world problems; the separation of our loved ones in the medical family is unbearable.

I have no real understanding of how someone whose spouse is in the service of our country really feels since I am "Outside Looking In." In our medical family, however, we do regret the conflict and will, in every way we can, support the spouses "Inside Looking Out." All hearts and prayers are with each and every physician of "our family" and with their spouses who are with us.

Everyone can pray that the Persian Gulf conflict will soon halt and "Let There Be Peace."

To get a true picture of the spouse who is "Inside Looking Out," I have asked Gloria Griffin to continue this article with her thoughts and feelings.

**Betty Schrod**  
**AKMA President**

# Medical Personnel and Their Families

## Inside Looking Out!

It's amazing how just one phone call can change your life. I'm sure you're thinking, we all get phone calls . . . so what's the big deal. I was asked to share with you what many families are experiencing because of one phone call about "OPERATION DESERT STORM."

Larry received a phone call because of his commitment to the US Navy. Like many other medical families, we have always taken our responsibility to help in our community and our country very seriously. I'm proud to know many of the physicians from Kentucky who are actively responding to the "Crisis in the Gulf." These physicians quickly packed their medical books and any special equipment they knew they would need in caring for the casualties of this war.

With only a few days' notice these physicians put their practice on hold, made decisions about what to do with patients, office personnel, office space, and insurance. This had to be done before they could even begin to think about their own family. The financial consequences of this activation causes a ripple effect in their community with the reduction of staff, not only in their office, but at the local hospitals. Many physicians will be faced with the potential of starting their medical practice all over again when they return in 6-12-18-24 months.

Even if your spouse isn't in the reserves, perhaps this would be the perfect time to sit down with them and make a strategic plan before you are faced with a crisis. I guess it's human nature to assume our spouses will be here to help in the management of our personal and business affairs, but this is obviously not the case for many families this year.

To all the physicians who are now serving this nation, **We Salute You**. As the spouse of an activated reservist, I'm proud and very supportive of the continued commitment our physicians have for this country. They are truly committed to **DUTY** and **COUNTRY**. They have left the security of their home and family and have truly gone that extra mile.

I hope these physicians will not be away from their families any longer than absolutely necessary. This is our opportunity to be supportive of the families who are affected by this recent activation. What these families need now are our prayers, support, and friendship to keep the faith while their spouses are away. They're experiencing firsthand the loss of a close relationship, the feeling of helplessness, sadness, and despair. But these families can accept this separation knowing their physicians are serving **our** country with pride. These spouses are accustomed to



dealing with the day-in and day-out problems, but many are also trying to keep their medical offices open and deal with the legal aspect of this crisis. In the first weeks of hostilities, the families left behind rarely ventured far from the television or radio. These families are on "a roller coaster" day in and day out. With the potential of ground warfare, they anxiously wait for a rare phone call from their spouse, and receiving a letter written two or three weeks ago is often the highlight of their day.

Thank you for allowing me the opportunity to thank these physicians, their spouses, and families for their continued contribution to this country. As you can see, we all have a personal stake in this conflict.

**Gloria J. Griffin (Mrs Larry P.)  
Louisville, KY**



# Letter from the Persian Gulf

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*I appreciate the editors authorizing use of their editorial space for me to recognize all of our many patients and colleagues who are serving our country with pride during the crisis in the Persian Gulf. KMA is now aware of 60 members who have been called to active duty (see page 129) and there are no doubt others that have not yet been reported to us. We are truly grateful to them and pray for their safe return to their families and friends.*

*Among those in Saudi Arabia is KMA State Legislative Activities Chairman and Past President Wally O. Montgomery, MD, of Paducah. The Headquarters Office just received a letter from Dr Montgomery, written five days before the conflict started, and I wanted to take this personal privilege to share it with you.*

*We salute our members who are all serving in the highest tradition of Kentucky physicians.*

Preston P. Nunnelley, MD  
KMA President

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Sahara Desert, Saudia Arabia  
11 January 1991

**D**ear Friends at KMA,

I'm addressing this to all of you and want you to know how much I appreciate your cards and letters which were shared with several fellow physicians and troops. They are also happy about any news from home and expressions of friendship.

I'm writing on a field table in a small tent with no heat and the outside temperature about 30° after a high today of 75°. With darkness the weather changes drastically. This desert is so vast and a wasteland with very few signs of life other than a few sheep and camel herds of the Bedouins. Even these animals must have their food needs by supplement and water is hauled in by tanker from distant wells. Learning to cope with sandstorms of 50 mph winds and zero visibility has tested us all. In fact, survival is of utmost concern even without the possibility of war.

I am finding my job of COSCOM (Corps support command) Surgeon is one of extensive planning, and I have had a crash course in military abbreviations and lingo. The details of how to plan for, place, design logistic needs of fuel, transportation, medical supplies, rations, and water for 3,300 hospital beds has been a nightmare. We do have 15 major hospitals in our Brigade with several medical battalions, cleaning companies, ambulance companies, and Medivac helicopter companies. There are about 6,500 medical troops under our command and 450 physicians. We'll support an entire CORPS of 140,000 troops under our flag with several added cav. divisions and ancillary units. Most of our days begin at 4 AM and end with exhaustion at midnight.



But enough of that for now. This letter is to tell you how much I have missed seeing all of you and working with you especially in planning for our legislative activities. Also, I'm sorry to have been unable to attend my duties at the December board meeting and the AMA interim meeting. All these functions were interesting and I do want to keep up on these activities.

You all must know how much I appreciated the DSA at the annual KMA meeting. The remarks were so meaningful to me and the family. I thank each of you for all your help and guidance for any part that I have contributed to the Association.

In the course of my life I have not found a better nor more dependable group of friends than you, my KMA family. I love and respect each of you and look forward to being with you again. Pray not for me alone but for the multiple thousands of young men and women over here who have not even started to reach the potential of their lives. If I can do anything to help "bind up the wounds" then this effort may not have been in vain.

Take care of yourselves and one another.

*Sincerely,*

*Wally Montgomery*



# Operation Desert Storm Briefs

## American Academy of Ophthalmology Offers Help During Operation Desert Storm

The American Academy of Ophthalmology reports that their president has offered the assistance of volunteer ophthalmologists to the Department of Defense and Veterans Administration hospitals during Operation Desert Storm.

"The American Academy of Ophthalmology, recognizing the potential shortage of ophthalmologists at some military hospitals in the US due to the deployment of many physicians in Operation Desert Storm, offers any assistance that may be needed," said Academy president George W. Weinstein, MD, in letters to the two federal agencies.

"Similarly, if during this action, the need for professional manpower should exist at any Veterans Administration Hospital or Department of Defense facility, the American Academy of Ophthalmology will support a call for volunteer ophthalmologists to work with state ophthalmological societies to provide support to this effort."

## Antibiotic Beads May Save Lives, Limbs in War

Strings of pea-sized antibiotic beads used at the University of Louisville may help save the lives and limbs of US soldiers in Operation Desert Storm.

Orthopedic surgeons **David Seligson, MD**, and **Stephen Henry, MD**, place the beads in wounds to stop infections in compound fractures where damage involves bone and soft tissue.

The beads should prove especially effective for treating

common combat injuries, which are ripe for infection due to debris imbedded in the wounds.

## Gulf-Related Service for Older MDs

News reports from the Persian Gulf contain many pictures of young soldiers barely born when the United States fought its last major war. However, among the ranks of those prepared to care for these young troops are some physicians whose military service dates to combat experience in World War II.

While a concentration of older physicians in particular units is somewhat unusual, reservist-physicians over age 55, or even 60, are by no means an anomaly, say military personnel.

According to a spokeswoman for the Army surgeon general's office, regular Army recruits are not accepted after age 34, but medical personnel are taken until age 65. Mandatory retirement is age 67, except in very rare cases where the Army allows a special exception, and all reservists must meet age-specific health standards. Military officials say they have compiled no statistics on the average age of physicians called into service.

Young reservist-physicians called into active duty often face serious financial problems, paying off medical school loans and finding coverage for new practices. Older physicians, however, say the difficulties they face are as serious — and sometimes more so.

Older *solo* practitioners face the most serious difficulties; not all have been able to find coverage. Some may have to sell or close their practice. Some cannot afford to keep a practice open indefinitely on their lower military salary.

At a more mature age, many are enjoying the personal and professional fruits of a long medical career, and have not been planning to retire from active practice. But the upheaval of the call-up may force a reassessment of their priorities.

Older physicians with established practices have more to lose than their younger colleagues, say several activated older reservists. But despite their concerns, the older physicians say they are still proud to serve.

## Important — Send Mail

Indications are that mail is valued above all else and helps to make life better for our troops in Operation Desert Storm.

A few things to remember:

- Mail is slow, so if possible, start sending it before the soldier arrives in the Middle East.
- Write often and don't wait for a return letter.
- Send packages (it will be as though the entire squad received something because they share).
- Don't forget the single soldier (there are groups that adopt them and send them things too).
- Videotapes, music cassettes, newspapers, and magazines are prized packages.

Address for troops in war zones:

### ARMY/AIR FORCE UNITS

Any Service Member  
U.S. Army/Air Force  
OPERATION DESERT STORM  
APO New York, New York 09848-0006

### NAUTICAL UNITS (Navy & Marines aboard ships)

Any Service Member  
OPERATION DESERT STORM  
FPO New York, New York 09866-0006

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## MARCH

**22-23 — Kentucky Thoracic Society 36th Annual Scientific Conference on Pulmonary Disease**, Radisson Hotel, Louisville, KY. Contact: Barry Gottschalk, PO Box 9067, Louisville, KY 40209-0067; 502/363-2652.

**25 — Dean's Hour — W. O. Johnson Lecture**, University of Louisville Health Sciences Center Auditorium, Louisville, KY. Contact: Laura Tucker, CME, University of Louisville, Louisville, KY 40292; 502/588-5329.

## APRIL

**4-5 — Operative Gynecologic Endoscopy**, University of Louisville Health Sciences Center Instructional Bldg, Louisville, KY. Contact: Laura Tucker, CME, University of Louisville, Louisville, KY 40292; 502/588-5329.

**5-6 — Geriatric Clinical Update: Treatable Causes of Dependency**, Holiday Inn Nationwide, Columbus, OH. Contact: Ohio State University, 800/492-4445.

**13 — Kidney Disease of Diabetes Mellitus (KDDM): Impact of Early Interventions**, Westin Hotel on Fountain Square, Cincinnati, OH. Contact: Kidney Foundation of Greater Cincinnati, 2330 Victory Parkway, Suite 305, Cincinnati, OH 45206; 513/961-8105.

**12-13 — General Endocrine Review**, Hyatt Regency Hotel, Lexington, KY. Contact: Ms Joy Greene, Director CME, 132 College of Medicine Office Bldg, U of K, Lexington, KY 40503-0086; 606/233-5161.

**14-17 — 59th Annual Assembly, Southeastern Surgical Congress**, Hotel Intercontinental, New Orleans, LA. Contact: Roger Sherman, MD, 69 Butler St, SE, Suite 314, Atlanta, GA; 404/221-0570.

**14-25 — 32nd Annual Postgraduate Institute for Pathologists in Clinical Cytopathology**, In-Residence Course B, Johns Hopkins University School of Medicine, Baltimore, MD. Contact: John K. Frost, MD, or Betty Ann Remley, 111 Pathology Bldg, The Johns Hopkins

Hospital, Baltimore, MD 21205, 301/955-8594.

**19-20 — Update Workshop in Diabetes: Pathogenesis and Treatment of Noninsulin-Dependent Diabetes Mellitus**, Hyatt on Capitol Square, Columbus, OH. Contact: Ohio State University, 800/492-4445.

**19-21 — Sports Medicine for Physicians**, Hyatt Regency Hotel, Lexington, KY. Contact: Ms Joy Greene, Director CME, 132 College of Medicine Office Bldg, U of K, Lexington, KY 40503-0086; 606/233-5161.

**25-27 — High Risk Pregnancy Postgraduate Course**, Hyatt Regency Hotel, Louisville, KY. Contact: Laura Tucker, CME, University of Louisville, Louisville, KY 40292; 502/588-5329.

**26-27 — Contemporary Pediatrics for the Practicing Physician**, Hyatt Regency Hotel, Lexington, KY. Contact: Ms Joy Greene, Director CME, 132 College of Medicine Office Bldg, U of K, Lexington, KY 40503-0086; 606/233-5161.

## MAY

**10-11 — Nineteenth Annual C. Dwight Townes Symposium**, The Seelbach Hotel, Louisville, KY. Norman S. Jaffee, MD, senior American surgeon in the field of lens implantation, will give Townes lecture; William Tasman, MD, ophthalmologist-in-chief at Wills Eye Hospital, will discuss retinal diseases and their treatment; and section on new neurodiagnostic testing presented. Contact: Mrs Rodman, 502/588-5466.

**17-18 — Annual Meeting**, The Virginia Society of Otolaryngology-HNS, Omni Waterside Hotel, Norfolk, VA. Contact: Donna Scott, 4205 Dover Rd, Richmond, VA 23221, 804/353-2721.

**18 — Nephrology Seminar**, University of Louisville Health Sciences Center Auditorium, Louisville, KY. Contact: Laura Tucker, CME, University of Louisville, Louisville, KY 40292; 502/588-5329.

**19-24 — Twenty-Second Family Medicine Review — Session II**, Hyatt Regency Hotel, Lexington, KY. Contact: Ms Joy

Greene, Director CME, 132 College of Medicine Office Bldg, U of K, Lexington, KY 40503-0086; 606/233-5161.

## JUNE

**9-13 — Fifteenth Symposium on Lung Disease**, The Cloister, Sea Island, GA. Contact: LaDonna Nail, Southern Medical Association, 35 Lakeshore Dr, Birmingham, AL 35219-0088; 1/800/423-4992; 205/945-1840.

**12-15 — American Academy of Family Physicians**, Kentucky Chapter, Annual Meeting, Galt House, Louisville, KY. Contact: Gayle Knopp, 502/451-0370.

**13-15 — 36th Great Smoky Mountains Pediatric Seminar**, Park Vista Hotel, Gatlinburg, TN. Contact: The University of Tennessee Department of CME, 1924 Alcoa Hwy, D-116, Knoxville, TN 37920; 615/544-9190.

**17-21 — Thirteenth Family Medicine Review**, Hyatt Regency Hotel, Louisville, KY. Contact: Laura Tucker, CME, University of Louisville, Louisville, KY 40292; 502/588-5329.

## JULY

**20-27 — 9th Annual Medical Seminar at Plummer's Great Slave Lake Lodge**, Northwest Territories, Canada. Sponsored by North Memorial Medical Center, University of Minnesota Department of Family Practice and St John's Regional Health Center, Springfield, MO. Contact: 612/588-9478.

## SEPTEMBER

**14 — Lasers and Beyond**, presented by N.D. Radtke, MD, and Humana Hospital Audubon. Category 1 credit. Contact: N.D. Radtke, MD, 240 Audubon Medical Plaza, Louisville, KY 40217; 502/636-2823.

## OCTOBER

**27-November 1 — Twenty-Second Family Medicine Review — Session III**, Hyatt Regency Hotel, Lexington, KY. Contact: Ms Joy Green, Director CME, 132 College of Medicine Office Bldg, U of K, Lexington, KY 40503-0086; 606/233-5161.

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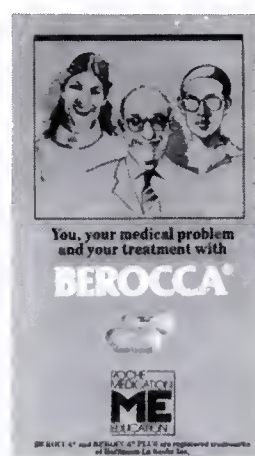
K. Jeffrey Mullins



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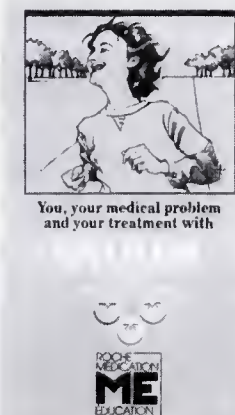
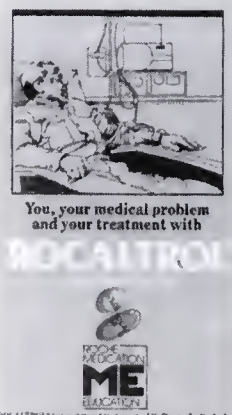
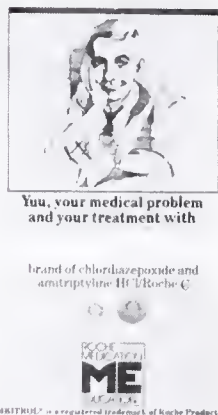
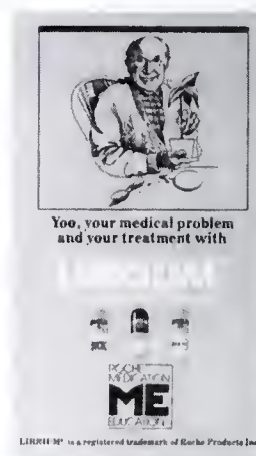
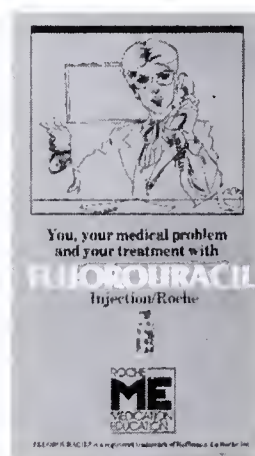
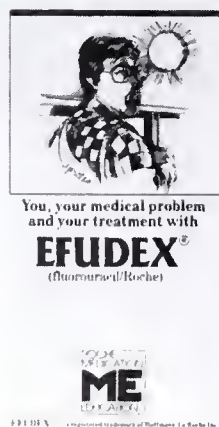
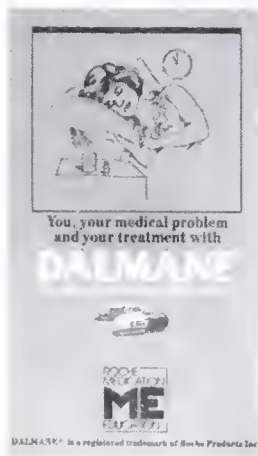


Your Roche representative offers you access – without expense or obligation – to a comprehensive library of patient information booklets designed to supplement rather than supplant your rapport with your patients.

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## RURAL KENTUCKY MEDICAL SCHOLARSHIP FUND

The Rural Kentucky Medical Scholarship Fund is accepting applications from residents of Kentucky, who have been accepted at the University of Kentucky College of Medicine or the University of Louisville Medical School. The Fund offers a \$10,000 loan for each year of medical school to a qualified recipient who is willing to practice and reside in a rural county in Kentucky for one year for each loan received. The interest rate is determined on May 1. Repayment options include low interest rates for recipients practicing in rural areas and loan forgiveness for those practicing in areas of the state with critical needs. The Fund is the oldest and most successful of its kind in the nation. The Rural Kentucky Medical Scholarship Fund has loaned approximately \$3 million to over 500 medical students. The deadline date for filing an application is **April 1**. Those interested in applying for a scholarship loan should contact the RKMSF Office at the Kentucky Medical Association Headquarters, 3532 Ephraim McDowell Dr, Louisville, KY 40205, or call 502/459-9790.



## Four New Officers Elected to KMA Board of Trustees

*During the 1990 KMA annual House of Delegates meeting held in Louisville, four new officers were elected to serve on the Board of Trustees. KMA congratulates the following members on their election and thanks them for their valuable leadership.*

**William P. VonderHaar, MD**, a Louisville family practitioner, was elected Secretary-Treasurer. Acknowledging his many years of dedicated service to his profession, the KMA delegation elected him to this three-year term.

Dr VonderHaar, 60, brings to this office extensive experience in organized medicine. A member of KMA since 1957, he has served on the Interspecialty Council, Professional Education Committee, and has served as a Delegate for Jefferson County for several terms. He is a charter fellow of the American College of Family Physicians and a member of the American Academy of Family Physicians.

Long active in medical education, Dr VonderHaar was the recipient of

KMA's Educational Achievement Award in 1988. He achieved distinction for his achievements in promoting and furthering the quality of family practice education, having served as the First Chairman of the Department of Family Practice at the University of Louisville. He currently is a clinical professor in the Department of Family Practice.

Dr VonderHaar earned his undergraduate degree in 1952 and his medical degree in 1956 from the University of Louisville. He served an internship at William Beaumont Army Hospital, El Paso, Texas, in 1956-57.

He has privileges at St. Anthony and Kentucky Baptist Hospitals.

A native of Davenport, Iowa, Dr VonderHaar and his wife, Elayne, live in Louisville. They have eight children.



**Joseph E. Kutz, MD**, was elected to serve a three-year term as 5th District Trustee.

A specialist in surgery of the hand and reconstructive microsurgery in Louisville since 1964, Dr Kutz earned a master's degree from the University of Detroit in 1955 and his medical degree from Michigan Medical School in Ann Arbor in 1958. He served a rotating internship at Springfield City Hospital in Ohio and completed his surgical residency at Louisville General Hospital. Following a one-year fellowship in hand surgery at the University of Louisville School of Medicine, he joined the hand surgery practice of Dr Harold Kleinert in 1964. In 1987, he was appointed Director of the Christine M. Kleinert Fellowship in Hand Surgery. Dr Kutz' current appointment at the University of Louisville School of Medicine is Clinical Professor of Surgery (Hand).

Active in KMA since 1963, Dr Kutz is a member of numerous medical societies including the American Society for Surgery of the Hand and the American College of Surgeons. He was active in the formation of two societies — the American Society for Reconstructive Microsurgery, for which he served an 18-month term as president in 1986 and 1987, and the International Society of Reconstructive Microsurgery, for which he is presently serving as treasurer. He is past president of the Jefferson County Medical Society and is currently serving as the president of the Medical Foundation of the Medical Society.

Dr Kutz is affiliated with Jewish Hospital, Humana Hospital University, Kosair Children's Hospital, and Frazier Rehab Center.

A native of Michigan, Dr Kutz, 62, and his wife, Mary Jane, reside in Louisville. They have three children.



**Mark F. Pelstring, MD**, a Covington family practitioner, has been elected 8th District Trustee for a three-year term.

Dr Pelstring, 43, graduated cum laude from Thomas More College and magna cum laude from the University of Louisville School of Medicine. He completed a one-year residency at St. Elizabeth Hospital in Covington prior to entering a private family practice in 1975.

Having joined KMA in 1976, Dr Pelstring is dedicated to the cause of organized medicine. His contributions include service as a KMA delegate from 1983 to 1987 and Alternate Trustee from 1987-1990. He is a past president of the Campbell-Kenton County Medical Society, diplomate of the American Board

of Family Physicians, a fellow of the American Academy of Family Physicians, and a member of the Kentucky Academy of Family Physicians and the American Society of Addiction Medicine.

Dr Pelstring is a past president of the St. Elizabeth Medical Center and a volunteer instructor in family medicine at the universities of Cincinnati, Louisville, and Kentucky, and a parttime instructor in the St. Elizabeth Medical Center Family Practice Residency Program.

A Covington native, Dr Pelstring and his wife, Peggy, have four children and reside in Ft. Mitchell.



**Paul R. Smith, MD**, a family practitioner in London, was elected to serve a three-year term as 15th District Trustee.

Dr Smith brings many years of experience to his KMA office. He has served as president of the Laurel County Medical Society for more than 9 years and has been a KMA delegate for several years. An active KMA member since 1960, committee memberships include Interspecialty Council, Care for Aging, Community and Rural Health, Advisory Committee on KPRO, Peer Review, and Ad Hoc Committee on Liability Insurance. Dr Smith is also a member of the American Academy of Family Practitioners, Southern Medical Association, and has been an Aviation Medical Examiner for the FAA since 1961. He was selected as Citizen Doctor of the Year by the Kentucky Academy of Family Practitioners in 1989.

Dr Smith, 60, earned his medical degree from the University of Louisville School of Medicine in 1956 and interned in 1956-57 at Good Samaritan Hospital, Lexington. He practiced as a flight surgeon in the United States Air Force from 1958 to 1960 and then began his private practice in London.

He has privileges at Marymount Hospital in London where he has held various offices including secretary, vice president, and president of the staff. He serves on the volunteer faculty at the University of Kentucky College of Medicine, Family Practice Department.

Dr Smith and his wife, Ann, reside in London. They have three children.





## PEOPLE



**Internist Dan A. Martin, MD, Executive Director for the Trover Foundation and chairman of the steering committee for the Madisonville Health Occupations School, was honored with the Governor's Certificate of Recognition for outstanding community service at the January meeting of the State Board for Adult and Technical Education.**

**McHenry S. Brewer, MD**, a Louisville surgeon, is leaving the Editorial Board of the *Journal* following 7 years of exemplary service. His contributions have been invaluable, and the *Journal* thanks Dr Brewer for giving so unselfishly of his time.

**Daniel W. Varga, MD**, has been appointed by the KMA Board of Trustees as the new scientific editor of the *Journal of the Kentucky Medical Association*. Dr Varga is an internist practicing in Louisville.

**Eugene H. Shively, MD**, a Campbellsville general surgeon, was recently elected to membership of the Southern Surgical Association at its annual meeting in Boca Raton, Florida.

Louisville plastic surgeon **Norman M. Cole, MD**, was elected president elect of the American Society of Plastic and Reconstructive Surgeons during the Society's recent annual meeting in Boston. Dr Cole is past president of the American Society for Aesthetic Plastic Surgery and is currently president elect of the Southeastern Society of Plastic and Reconstructive Surgeons.

**Joseph Sanfilippo, MD**, U of L Department of Obstetrics and Gynecology, served as program chairman for the American Fertility Society annual meeting held recently in Washington, DC.

The American Academy of Family Practitioners Board of Directors made appointments to the Academy's commissions and committees at its recent meeting in Kansas City, MO. KMA member physicians included in the appointments are **Max Crocker**, Lexington, Commission on Continuing Medical Education; **Stephen B. Kelley**, Somerset, Committee on Health Education; and **Walter H. Zukof**, Louisville, Publications Committee. According to the most recently available information on AAFP constituent chapter annual meeting dates, the Kentucky meeting will be held June 12-15 at the Galt House in Louisville.

## UPDATES

### March 30th "National Doctors' Day"

Among the first reservists called to action in "Operation Desert Storm" in

Saudi Arabia were men and women of the medical community from cities across our nation. It is therefore most fitting that March 30, 1991, has been designated "National Doctors' Day," by a Proclamation signed by President George Bush, following Joint Resolutions overwhelmingly adopted by the United States Senate and House of Representatives. This Proclamation enables the citizens of the US to publicly show appreciation for the role of physicians "in caring for the sick, advancing medical knowledge, and promoting good health."

### UK Establishes Gamma Knife Radiosurgery Program

The University of Kentucky Hospital and the College of Medicine's Division of Neurosurgery recently announced the establishment of a new Stereotactic Radiosurgery Program. The cornerstone of this new program is the Leksell Gamma Knife. This unique surgical tool will be used to primarily treat deepseated and often inaccessible tumors and blood vessel malformations in the brain.

The \$2.6 million, 20-ton instrument that uses radiation is in essence "brain surgery without a knife."

Only six hospitals in the US have a gamma knife. They include Presbyterian-University Hospital of Pittsburgh; University of Virginia, Charlottesville; Chicago Neurosurgical Center; Atlanta Piedmont Hospital; Dallas Presbyterian Hospital, and Mayo Clinic Foundation's St. Mary's Hospital.

"The gamma knife is the safest and very best method for treating certain types of brain conditions," said **Dr A. Byron Young**, Professor and Chairman of Surgery and Chief of Neurosurgery. "We are dedicated to providing patients in our referral area the same type of treatment as they

would be able to get at the Mayo Clinic."

### New AMA Guidelines on Drug Industry Gifts

In December, the AMA issued "tough new guidelines" on the ethics of pharmaceutical and medical equipment industry promotional practices. The guidelines require that physicians: not accept any gift of substantial value even if it is educational in nature; not accept payment for the costs of travel, lodging, or other personal expenses when attending conferences or meetings; reject any gift when strings are attached; disclose publicly any financial support for conferences.

### UK Children's Cancer Research Fund Receives Major Gift

Proceeds raised during the 1990 High Hope Steeplechase and Rolex Kentucky International Three-Day Event recently were contributed to the University of Kentucky Children's Cancer Research Fund.

**Dr John W. Garden**, Chairman of the High Hope Steeplechase Board of Directors, and John V. Boardman, Jr, President of Equestrian Events, Inc, presented a check for \$35,000 to the University. **Dr Jacqueline Noonan**, Chair, Department of Pediatrics, and **Dr Emery Wilson**, Dean, College of Medicine, were among those present to receive the generous gift.

High Hope Steeplechase has contributed proceeds raised during its annual event since 1975. In 1988 Rolex joined High Hope in earmarking proceeds to benefit the UK program.

### Rudd Endowment to Fund Surgical Research at U of L

The Jewish Hospital Foundation has announced that \$500,000 will be

available over the next 5 years to fund research programs for the University of Louisville School of Medicine Department of Surgery.

The endowment was created by a \$500,000 gift from benefactors Mason and Mary Rudd of Louisville.

The Mason and Mary Rudd Surgical Teaching Endowment has since grown to more than \$1 million, with the investment earnings earmarked for new research programs.

Proposals for teaching and research awards are being coordinated by U of L's **Hiram C. Polk, Jr, MD**, and **Ben A. Reid, Sr, MD**, professor and chairman, Department of Surgery.

### Nicholas J. Pisacano Endowed Chair

The UK College of Medicine has established the Nicholas J. Pisacano Endowed Chair in Family Practice as a memorial tribute to **Dr Nicholas Pisacano**, whose recent untimely death shocked the medical profession throughout the nation and the world.

Recognized worldwide as a great physician, teacher, and friend among his colleagues and students, Dr Pisacano labored tirelessly as founder and Executive Director of the American Board of Family Practice to make it one of the largest, strongest, and most respected medical specialty boards in the world.

"Nick Pisacano's unexpected death has focused the attention of friends and medical professionals worldwide on the tremendous impact he had on the specialty of family practice, medical education, and medicine at large," said **Dr Alan K. David**, Chairman, Department of Family Practice. "Establishing this chair in his memory will ensure that his exemplary standards of educational excellence and significant contributions to family practice will be perpetuated long into the future."

### UK Expands Role in Rural Health Care

University of Kentucky officials recently joined Governor Wallace Wilkinson, legislators, and community leaders to announce the establishment of a Center of Excellence for Rural Health. The announcement marked the beginning of an unprecedented partnership between state government, UK, and Kentucky's citizens to address unmet health care needs of rural Kentucky.

Under the provisions of Senate Bill 239, better known as Kentucky's Health Care Reform Act of 1990, UK has been charged to expand its existing role in meeting the health care and educational needs of rural Kentucky. In no other state has such comprehensive legislation been developed and enacted to better serve the citizens' health care needs in rural areas.

The center will conduct research in rural health policy; be responsible for administering a family practice residency program; offer master of science degrees in nursing; establish an emergency medicine clinical residency program in rural regional hospitals; establish off-site bachelor programs for physical therapy and lab technology; and provide continuing education for health care professionals. The center will be located in Hazard.

According to **Dr Peter Bosomworth**, chancellor of the UK Medical Center, the planning phase of the initiative should be finished in 1991. "The expanded program offerings should be launched quickly, with plans calling for initiating the master's degree in nursing program by August 1991," he said. "The initiative should be fully developed in 4 years."

Dr Bosomworth added that one of the key goals of the initiative is providing training for health care professionals in rural areas so they will not have to leave the area for training.



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**NEW MEMBERS**

*Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.*

**Calloway**

**Danny T. Berry, MD** — EM  
1548 Whippoorwill Way, Murray 42071  
1981, U of Arkansas

**Daviess**

**Dennis J. Adams, MD** — AN  
2108 Fieldcrest Dr, Owensboro 42301  
1986, U of Louisville

**Juan M. Cardenas, MD** — AN  
221 Mayfair Dr #409, Owensboro 42301  
1986, U of Louisville

**Ross W. Cotton, MD** — AN  
2742 Western Pkwy, Owensboro 42301  
1986, U of Louisville

**James A. Holder, MD** — AN  
3510 Ashlawn Dr, Owensboro 42301  
1982, U of Kentucky

**Fayette**

**John W. Gilbert, MD** — NS  
750 Shaker Dr #510, Lexington 40504  
1984, U of Kentucky

**William D. Newton, MD** — S  
1725 Harrodsburg Rd #5, Lexington 40504  
1979, U of Louisville

**John L. Wolford, Jr, MD** — GE  
4882 Wyndhurst Dr, Lexington 40515  
1980, Vanderbilt U

**Franklin**

**Porter L. Ramsey, IV, MD** — EM  
10 Pheasant Dr, Frankfort 40601  
1987, U of Kentucky

**Hardin**

**Aurora L. Abang, MD** — PUD  
597 Rue La Grande, Elizabethtown 42701  
1963, Manila Central U

**David Anh Duy Dao, MD** — IM  
4657 Shepherdsville, Elizabethtown 42701  
1974, Saigon Faculty of Medicine

**Elaine D. Martin, MD** — PD  
702 Grant Cr, Elizabethtown 42701  
1981, U of Louisville

**Scott A. Stanek, DO** — GP  
4041 Park Rd, Ft Knox 40121  
1987, Kansas City College of Osteopathy

**Harrison**

**Galen E. Castle, MD** — R  
Box 70, Cynthiana 41031  
1981, Marshall U

**Henderson**

**Jon P. Kuzmic, MD** — AN  
7091 E Cherry St, Evansville IN 47715  
1985, Indiana U

**James C. Macke, MD** — ORS  
110 Third Street #370, Henderson 42420  
1983, Indiana U

**W. Mark Vickers, MD** — FP  
319 8th St, Henderson 42420  
1986, U of Kentucky

**Jefferson**

**Lisa M. Cipolla, MD** — IM  
2457 N Peterson Ct, Louisville 40206  
1987, U of Louisville

**Joel P. Garmon, MD** — S  
220 SW Professional Bldg, Louisville 40272  
1985, U of Louisville

**Dennis A. Sparks, MD** — FP  
4810 Watterson Tr, Louisville 40291  
1985, U of Louisville

**David A. Vanbockel, MD** — AN  
8106 Ravencrest Ct, Louisville 40222  
1972, U of Minnesota

**Paul D. Yochim, DO** — AN  
3048 Ledgebrook Ct, Louisville 40241  
1982, Kirksville College of Osteopathy

**Lawrence**

**Eugene R. Trout, MD** — S  
PO Box 239, Louisa 41230  
1963, George Washington U

**Morgan**

**James E. Shaw, MD** — GP  
PO Box 612, West Liberty 41472  
1954, U of Louisville

**Northern Kentucky**

**W. Mark Gutowski, MD** — OTO  
7575 US 42, Florence 41042  
1982, Tulane

**Mark A. Knibbe, MD** — PS  
20 Medical Village Dr #196, Edgewood 41017  
1988, Creighton U

**Pulaski**

**Dennis A. Lynn, MD** — IM  
PO Box 700, Somerset 42502  
1986 St. George's U

**Rockcastle**

**Carl W. Kesner, MD** — GP  
Rockcastle Clinic, Mt. Vernon 40456  
1967, U of Tennessee

**Whitley**

**Joseph E. Wolpmann, DO** — GP  
PO Drawer O, Corbin 40702  
1956, Kansas City Medical College

**New In-Training****Fayette**

**John C. Gross, MD** — IM

**Jefferson**

**Martin D. Bomalaski, MD** — P  
**Karen R. Habenstein, MD** — PUD

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**DEATHS**

**Donnan B. Harding, MD**  
Lexington  
1896-1990

Donnan B. Harding, MD, a radiologist, died November 5, 1990. Dr Harding was a 1920 graduate of State University of Iowa College of Homeopathic Medicine. He became active in KMA in 1926 and was a life member.

**Charles G. Baker, MD**  
**Sarasota, FL**  
**1902-1990**

Charles G. Baker, MD, a dermatologist, died November 17, 1990. A 1934 graduate of the University of Louisville School of Medicine, Dr Baker was a life member of KMA.

**Ronald G. Goebel, MD**  
**Louisville**  
**1937-1991**

Ronald G. Goebel, MD, a radiologist, was killed January 25, 1991, in a bicycle accident while vacationing in Costa Rica. Dr Goebel was a 1964 graduate of the University of Louisville School of Medicine and an active member of KMA.

**Meyer Max Harrison, MD**  
**Louisville**  
**1908-1991**

Meyer Max Harrison, MD, an internist, died January 31, 1991. Dr Harrison graduated from the University of Louisville School of Medicine in 1934, was a past president of the Louisville Society of Internists, and a life member of KMA.

**John B. Larson, MD**  
**Louisville**  
**1910-1991**

John B. Larson, MD, a retired pediatrician and past president of the Louisville Pediatrics Society, died January 31, 1991. A 1938 graduate of the University of Iowa School of Medicine, Dr Larson was a life member of KMA.

# Prevention:

## Rx for Health Care in the 90s

*KMA Annual Meeting · Sept 29 - Oct 3*  
*Hyatt Regency Hotel · Lexington, KY*



# **Pfizer Pharmaceuticals First Major Manufacturer to Make Products Available to Kentucky Physicians Care**

Thousands of low-income Kentuckians may receive free prescriptions and pharmacy services through a new program, "Kentucky Pharmacy Providers," that was launched in July 1990.

An agreement has been reached with the Kentucky Health Care Access Foundation, the Kentucky Pharmacists Association, and Pfizer/Roerig Pharmaceuticals to make Pfizer Labs' and Roerig's entire line of prescription drug products available to KPC patients *at no charge*. (To be eligible for the KPC program, patients must have incomes at or below the Federal Poverty Income guidelines and cannot be eligible for any government assistance programs such as Medicare and Medicaid.)

Pfizer Labs and Roerig sales representatives are calling on KPC participating physicians to make them aware of the full range of Pfizer/Roerig products available to KPC, and physicians are encouraged to see them when possible.

In extending this access to prescription drugs, Pfizer will make its Pfizer Labs and Roerig brand pharmaceuticals available at no cost, and participating pharmacists will dispense them without charge to eligible ambulatory patients. The estimated combined value of these goods and services exceeds \$1 million. *Only prescriptions written for Pfizer/Roerig products for KPC eligible patients by KPC participating doctors will be filled through the Kentucky Pharmacy Providers Program.*

The Pfizer and Kentucky Pharmacists Association program will help fill a significant void in KMA's effort to help the less fortunate. The Kentucky Health Care Access Foundation and KPC Operating Committee are hopeful that other manufacturers will offer their assistance in the future.

If you have questions, or for those physicians not currently participating in KPC who wish to participate, please contact the KPC referral office — 1/800/633-8100, or the KMA Headquarters Office — 1/502/459-9790.

**PLEASE REFER TO THE FOLLOWING PAGES  
FOR A LIST OF AVAILABLE  
PFIZER/ROERIG PRODUCTS  
AND A LIST OF PARTICIPATING PHARMACIES**

# Pharmaceuticals available to Kentucky Physicians Care

These Pfizer/Roerig pharmaceuticals may be prescribed and dispensed under the program:

## Pfizer Labs

Antiminth® (Pyrantel pamoate) OTC  
Cortril® Topical Ointment 1% (Hydrocortisone) Rx  
Diabinese® Tablets (Chlorpropamide) Rx  
Diabinese® Tablets Unit-Dose Pak (Chlorpropamide) Rx  
Feldene® Capsules (Piroxicam) Rx  
Feldene® Capsules Unit-Dose Pak (Piroxicam) Rx  
Minipress® Capsules (Prazosin HCl) Rx  
Minipress® Capsules Unit-Dose Pak (Prazosin) Rx  
Minizide® 1 Capsules (1 mg. Prazosin and 0.5 mg. Polythiazide) Rx  
Minizide® 2 Capsules (2 mg. Prazosin and 0.5 mg. Polythiazide) Rx  
Minizide® 5 Capsules (5 mg. Prazosin and 0.5 mg. Polythiazide) Rx  
Moderil® Tablets (Rescinnamine) Rx  
Procardia® Capsules (Nifedipine) Rx  
Procardia® Capsules Unit-Dose Pak (Nifedipine) Rx  
Procardia XL® (Nifedipine) Extended Release Tablets Rx  
Procardia XL® (Nifedipine) Extended Release Tablets Unit-Dose Pak Rx

Renese® Tablets (Polythiazide) Rx  
Renese®-R Tablets (2 mg. Polythiazide and 0.25 mg. Reserpine) Rx  
Sustaire® (Theophylline anhydrous) Rx  
Terramycin® Capsules (Oxytetracycline HCl) Rx  
Vansil™ Capsules (Oxamniquine) Rx  
Vibra-Tabs® (Doxycycline hyclate) Rx  
Vibra-Tabs® Unit-Dose Pak (Doxycycline hyclate) Rx  
Vibramycin® Calcium Syrup (Doxycycline calcium oral suspension) Rx  
Vibramycin® Hyclate Capsules (Doxycycline hyclate) Rx  
Vibramycin® Hyclate Capsules Unit-Dose Pak (Doxycycline hyclate) Rx  
Vibramycin® Monohydrate for Oral Suspension (Doxycycline monohydrate) Rx  
Vistaril® Capsules (Hydroxyzine pamoate) Rx  
Vistaril® Capsules Unit-Dose Pak (Hydroxyzine pamoate) Rx  
Vistaril® Oral Suspension (Hydroxyzine pamoate) Rx

## Roerig

Antivert® (Meclizine HCl) Rx  
Antivert® Tablets Unit-Dose Pak (Meclizine HCl) Rx  
Atarax® (Hydroxyzine HCl) Rx  
Atarax® Tablets Unit-Dose Pak (Hydroxyzine HCl) Rx  
Bonine® Chewable Tablets (Meclizine HCl) OTC  
Cefobid® (Cefoperazone sodium) Rx  
Diflucan® (Fluconazole) Oral and Parenteral Antifungal Rx  
Diflucan® (Fluconazole) Unit-Dose Pak Oral and Parenteral Antifungal Rx  
Emete-con® IM/IV (Benzquinamide HCl) Rx  
Geocillin® (Carbenicillin indanyl sodium) equivalent to 382 mg. carbenicillin Rx  
Geopen IM/IV (Carbenicillin disodium) Rx  
Glucotrol® Tablets (Glipizide) Rx  
Glucotrol® Tablets Unit-Dose Pak (Glipizide) Rx  
Heptuna® Plus Capsules (Iron plus vitamins and minerals) Rx  
Hydrocortisone Powder (Hydrocortisone USP micronized) Rx  
Isoject® Permapen® (Penicillin G benzathine) Aqueous Suspension Rx  
Marax® (Hydroxyzine HCl [ATARAX®]-Theophylline-ephedrine sulfate) Rx  
Navane® Capsules (Thiothixene) Rx  
Navane® Capsules Unit-Dose Pak (Thiothixene) Rx  
Navane® Concentrate (Thiothixene HCl) Rx  
Navane® Intramuscular (Thiothixene HCl) Rx  
Pfizerpen® for Injection (Penicillin G potassium) Buffered Rx

Pfizerpen®-AS (Penicillin G procaine) Aqueous Suspension Rx  
Polymyxin B Sulfate Sterile Rx  
Sinequan® Capsules (Doxepin HCl) Rx  
Sinequan® Capsules Unit-Dose Pak (Doxepin HCl) Rx  
Sinequan® Capsules Unit of Use Pack (Doxepin HCl) Rx  
Sinequan® Oral Concentrate (Doxepin HCl) Rx  
Spectrobid® Oral Suspension (Bacampicillin HCl) Rx  
Spectrobid® Tablets (Bacampicillin HCl) Rx  
Streptomycin Sulfate Rx  
Tao® Capsules (Troleandomycin) Rx  
Terra-Cortril® Ophthalmic Suspension (Oxytetracycline HCl and hydrocortisone acetate) Rx  
Terramycin® Intramuscular Solution (Oxytetracycline) Rx  
Terramycin® Ophthalmic Ointment with Polymyxin B Sulfate (Oxytetracycline HCl with polymyxin B sulfate) Rx  
Terramycin® Vaginal Tablets with Polymyxin B Sulfate (Oxytetracycline HCl with polymyxin B sulfate) Rx  
Unasyn® (Ampicillin sodium/sulbactam sodium) Rx  
Urobiotic® 250 (250 mg. Oxytetracycline HCl 250 mg. sulfamethizole 50 mg. phenazopyridine HCl) Rx  
Vibramycin® Intravenous (Doxycycline hyclate for injection) Rx  
Vistaril® Intramuscular Solution (Hydroxyzine HCl) Rx  
Vistaril® Intramuscular Solution Unit-Dose Vials (Hydroxyzine HCl) Rx



# PARTICIPATING PHARMACIES

## KPC PHARMACY PROVIDER PROGRAM

**Adair**  
DBA Columbia Pharmacy  
Madison Square Drugs & Chymist

**Allen**  
Carpenter Dent Drugs  
Stovall Prescription Shop  
Williams Pharmacy

**Anderson**  
The Medicine Shoppe

**Borren**  
Ely Drugs, Inc.  
Glasgow Prescription Center  
Tawne & Country Drugs

**Bell**  
Farris Drugs  
Jeff's Pharmacy  
Kraeger Company  
Pineville Has. Out-Pt Pharmacy  
SuperX Drugs  
Tatol R Care Pharmacy

**Boone**  
Boone County Drugs  
Burlington Pharmacy  
SuperX Drugs  
Turfwoy Pharmacy

**Bourbon**  
Glen's Drugs  
Horne's Ardrey Drug  
The Medicine Shoppe

**Boyd**  
McMeans Pharmacy  
SuperX Drugs

**Boyle**  
Grider Pharmacy  
Leake Pharmacy  
SuperX Drugs  
Taylar Drug

**Brocken**  
Dean's Pharmacy

**Breathitt**  
Jackson Prescription Ctr

**Breckinridge**  
Save-Rite Drugs  
Tawne & Country Pharmacy

**Bullitt**  
Taylor Drugs

**Caldwell**  
Payless Discount Pharmacy  
The Pharmacy Carner Enterprise

**Calloway**  
Clinic Pharmacy  
Holland Drugs  
Safe-T Discount Pharmacy  
Walter's Pharmacy

**Campbell**  
Alexandria Drugs  
Martin's Pharmacy  
Newport Drug Center  
SuperX Drugs

**Corroll**  
Parklane Pharmacy  
Webster Drugs

**Cortor**  
Horton Brather & Brawn  
Rase Pharmacy

**Christian**  
Express Pharmacy  
Horn Prescription Shop  
Jennie Stuart Medical Center  
Sove More Drug  
The Medicine Shoppe

**Clock**  
Corner Drug Store  
Doy Drugs  
SuperX Drugs

**Cloy**  
Family Drug Center  
H & N Drug  
Medi Center Drugs

**Crittenden**  
Glenn's Apothecory

**Cumberland**  
Smith Pharmacy

**Daviess**  
Donhauer Drug Company  
Emery Centre Pharmacy  
Greene's Pharmacy  
Harrel's Drug Store  
Moyfair Pharmacy  
Medical Plazo Pharmacy  
Medicine Shoppe  
Nation's Medicines  
Taylar Drug #21  
Wal-Mart Pharmacy

**Edmonson**  
Prescription Shop

**Fayette**  
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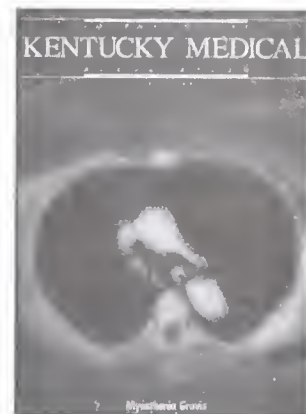


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# Recent Leadership Activities

**F**ebruary was a busy time for KMA and its officers. We attended the annual AMA Leadership Conference which is nationally regarded as **the** premier meeting on "the latest" in medical socio-economics. The speakers were provocative and controversial, but educational as well. Secretary of HHS, Louis Sullivan, MD, "made our day," when he reaffirmed support for Inspector General Richard Kusserow.

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**“Secretary of HHS, Louis Sullivan, MD, “made our day,” when he reaffirmed support for Inspector General Richard Kusserow.”**

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The KMA House of Delegates and practically every state medical association support AMA's position that Kusserow should be fired.

The AMA believes Kusserow acted unfairly and irresponsibly in Medicare and Medicaid fraud investigations of physicians. AMA called for Kusserow's dismissal following a long history of complaints that the Inspector General's office has been unfair to physicians in fraud

investigations and violated their constitutional rights.

Mr Kusserow was the focus of the September 20 segment of ABC TV's "Prime Time Live." In that segment, ABC reported that Health and Human Services used a "bounty system" and quotas to reward fraud investigators for bringing sanctions against physicians. Kusserow denied that such rewards had been used, but later admitted that merit pay had been "indirectly tied" to the number of cases brought forth by investigators. Even though the Administration has been unresponsive to our concerns, we plan to continue working with AMA to seek Kusserow's ouster.

Former Chief Justice of the Supreme Court Warren Burger made an excellent presentation entitled "Law and Medicine: Finding Common Professional Ground." While it is difficult to remember the exact quote, Burger essentially said, "Never, never seek the services of a doctor or lawyer who finds it necessary to advertise to seek patients or clients." Burger was Chief Justice when the Court, in a 5-4 vote, ruled that physicians and attorneys could legally advertise.

A highlight of the meeting was Past President of the AMA Alan R. Nelson, MD's, response to West Virginia's Senator Jay Rockefeller's outline of the Pepper Commission's prescription for improving the "health of health care." The presentation is printed in its entirety in this issue of the *Journal*.




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**“William Natcher, Dean of Kentucky's Congressional Delegation, was honored as a recipient of the AMA's Nathan Davis Award. Representative Natcher is a valued friend of medicine and one of Congress's most powerful lawmakers.”**

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**“ . . . . Burger essentially said, ‘Never, never seek the services of a doctor or lawyer who finds it necessary to advertise to seek patients or clients.’ ”**

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During February, we also journeyed to Washington for two purposes. First of all, William Natcher, Dean of Kentucky's Congressional Delegation, was honored as a recipient of the AMA's Nathan Davis Award. Representative Natcher is a valued friend of medicine and one of Congress's most powerful lawmakers. We also called on other members of the Kentucky delegation and discussed various federal initiatives, especially the Bush Administration's proposal to reduce Medicare spending by \$25 billion over the next 5 years.

While the above-listed events were enjoyable and learning experiences, the Special Session of the Kentucky General Assembly was just the opposite. The General Assembly was responsive to our support for strengthening DUI laws and separating medical waste from the solid waste management bill, two original concerns. However, the introduction of House Bill 21 (HB 21) to address the \$25 million shortfall in Medicaid was quite an experience. I won't dwell on our efforts in this article as you have been mailed a Legislative Bulletin, a three-page letter in question and answer format, and a *Communicator*, which fully address the legislation and KMA's position. However, it is important to point out that of the options KMA had, HB 21 is

least restrictive to the patient and physician. The shortfall was a product of the federal government, which added 60,000 recipients to Medicaid rolls leaving funding to the Kentucky General Assembly.

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**“ It is important to point out that of the options KMA had, HB 21 is least restrictive to the patient and physician. ”**

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As you can see, this has been a busy time. We are here to serve and represent members and need continuing input and suggestions. We look forward to seeing many of you as we visit the various KMA Trustee Districts.

**Preston P. Nunnelley, MD**  
**KMA President**

# Doctor Nelson Responds to Pepper Commission

**KMA President Preston P. Nunnelley, MD, led Kentucky's Delegation to the AMA National Leadership Conference in February. One of the presentations made was by AMA Past President Alan Nelson, MD, immediately following a presentation by Senator Jay Rockefeller of West Virginia. It seemed most timely and appropriate to share it with the KMA membership. Those attending the conference felt it to be thought provoking. See President's Page (page 159).**

Senator Rockefeller has outlined the Pepper Commission's prescription for improving the health of health care in this country.

Let me say at the outset that we agree with the basic principles, and most of the specifics of his commission's report, and we are allied in our determination to find constructive, do-able approaches to deal with problems that everyone knows exist.

Let me propose four assumptions with which most of us agree:

1. At its best, medical care in the United States is unsurpassed. Students and physicians from throughout the world come here to train if they can. Our centers of excellence have a global patient base. Few of us would choose to have a serious illness in another country, if we had a choice. Eighty-seven percent of us have access to a good health care system.
2. Thirty-one million people who lack adequate health insurance is a disgrace for a country as rich as ours. No woman should complete her pregnancy without prenatal care. Everyone should be immunized. Everyone should have cost-effective disease prevention screening.
3. The present escalation of health care costs in the US is unacceptable and must be altered.

4. Significant change (not just tinkering) in the way medical care is provided and financed is necessary and desirable.

I will give my view of each of these dimensions of health care — access, cost, and quality, and outline where I think we should go in the future.

First, let me begin with a brief historical review, because efforts to enhance access to health insurance are not a recent phenomenon.

Over six decades ago, in 1926, growing concern about the costs and distribution of medical care prompted the formation of the Committee on the Cost of Medical Care. It was chaired by a former President of the AMA, Lyman Wilber, MD, who became Hoover's Secretary of the Interior. This blue ribbon committee prepared 27 research reports, the last in 1932, and expressed alarm about the spiraling cost of health care (\$3.66 billion per year, or 4% of the national income). It also gave the first reliable breakdown of the medical dollar (29.8 cents paid to physicians versus 20 cents in 1989).

In 1935, the California Medical Association endorsed compulsory health insurance, as had the American College of Surgeons in 1934. President Roosevelt's initiatives in this area were stopped by WW II.

In 1944, 68% of the public thought



## Doctor Nelson Responds to Pepper Commission

it was a good idea for social security to also pay for doctors and hospital care, but only 51% of those polled were willing to pay higher social security taxes to fund it.

In 1950, the AMA conducted an intense campaign against what it called socialized medicine; in 1965, we warned that estimates of Medicare costs were badly understated; and in 1970, President Nixon said that his administration must confront rapidly escalating costs. "We face a massive crisis in this area," he said, "unless action is taken within the next 2 or 3 years, we will have a breakdown in our medical system."

In 1970, three fourths of the public agreed with the statement "There is a crisis in health care in the United States." That year, the AMA introduced its national health insurance proposal, and at the AMA Leadership Conference in about 1975, Bill Fullerton, Staff of the House Ways and Means Committee, surprised his audience by saying he didn't believe we would have national health insurance until 1978. Everyone expected it sooner.

Beginning with the election of President Reagan, we saw new optimism and an assertion that competition and voluntarism would solve the problems of cost and access. Instead, predictably, we have seen increasing costs, eroded professional freedom, and unacceptably larger numbers of patients unable to receive the full range of needed services because they have no insurance.

**W**hat are the environmental factors that must be considered as we propose programs for needed health care reform? There are three that I wish to address: we are a media driven society; we have a budget-driven government policy; and the direction of policy is often determined by special interests. Let me speak briefly to each.

**M**edia and electronic communications capability have completely changed the way public policy is formulated, framed, and advanced. It sometimes seems that Bryant Gumble has more influence than Louis Sullivan, unless Dr Sullivan uses Mr Gumble.

Imagine the previously unimagined ability to influence the dynamics of global power that CNN shows in the Gulf conflict. Saddam quickly figured it out. Wolf Blitzer has become an unlikely household word.

The thirst for health-related information seems unquenchable. We want to know how to take care of ourselves.

Social policy regarding health care is similarly influenced by the barrage of health related information.

JAMA changes its day of publication to better use the week's time frame for coverage; my patients find out about a gene related osteoarthritis before the information is published in peer-reviewed literature (and the story is misreported in print and electronic media in a way that misleads my patient's expectations).

Miracles are heralded, but never with a fiscal note. A child has a successful liver transplant and it's reported as a medical miracle. The family sues the hospital because it can't find a donor for another transplant after the second fails, and it's reported as an interesting legal case; but no one talks about the cost of those procedures. Bone density screening for all women to determine osteoporosis risk, or bone marrow transplants as a cure for AIDS are tossed on the nightly news with no consideration of what it would cost to make those technologies available.

And as people hear more health related information; as they hear conflicting recommendations about, for example, mammogram screening, or estrogen use; as they hear information that is downright wrong from quacks on ra-

dio-talk shows, for instance; as they hear about inaccurate pap smear screening or fatigue impaired residents, they become simultaneously enamored and distrustful of our technology. Nonetheless, they want the miracles, often self-refer, pick from the health care menu (one from Column A, two from Column B), want the best and want it now.

**W**e have a budget driven government policy. OMB seems to run things within the administration. "Read my lips" softened a bit with sin taxes last year, but that so-called revenue enhancement is peanuts in the face of the savings & loan bailout, and a new price tag on the Gulf War. And talk of confronting the deficit with a capital gains tax cut still sounds like voodoo economics to many.

We are talking about access to care today, and we might as well do it with realism and clarity and discuss what various proposals would cost, and how we as a nation would pay for the program we would enact. That fact alone makes us and the Pepper Commission unique among the many groups that want free care for all with no honest projection of what that would cost.

**W**hat special interests are driving health policy?

Let's start with the militant affluent elderly. Their power was amply demonstrated by the pressure they successfully applied to Congress to repeal the catastrophic protection legislation. They turned their backs on the needs of their less fortunate fellows because of a maximum \$800 additional premium per year for the most wealthy. And how long will the transfer of debt to the young working couple continue as cost shifts from government funded programs continue unabated?

Labor was a powerful force in the 70s, fell on hard times in the 80s, is now again an important player, and will become more important because the large middle class is searching for an advocate, as it finds business cutting corners in a way that hurts.

But the special interest that will force change — perhaps drastic change — perhaps some of it unwise — is business. Business has the means, the knowledge, and is developing the organizational structure to put capping systems in place as it becomes more frustrated and more desperate about its inability to control its health care budget.

And our special interest group. What is its role, and does it have any clout? We most certainly have a responsibility to be a constructive, credible participant in this environment of accelerating change. But our ability to influence policy in directions that best meet the unique needs of Americans, while at the same time preserving fundamental values of the profession, depends on our ability to forge consensus, within and outside the profession.

And that is why we developed Health Access America; we are a player in these times of inevitable change.

Let me return to our earlier basic premise: fundamental change in our health care system is necessary and desirable. The key questions are, "what kind of change is needed?" and "how do we achieve it?"

A good deal of attention has been given to systems that have developed in other industrial countries, and speculation about their suitability in the US continues. Should we attempt to implement the Canadian or German or Swedish system, for instance?

First, I believe it is undesirable to do so, but, more important, it is not feasible. Americans are uniquely Amer-

ican, have different expectations, and have a different relationship with their government. We are not likely to increase taxes enough to adopt the Canadian system (up to \$330 billion), Americans don't like to stand in line (they'll sue before they queue), and our experience with Medicare makes us laugh at the assertion that government would do it more simply. Government can't do anything simply. Can you imagine the Medicare data system being dismantled if we have a government based single-payer system? Of course not.

Not only would the tax burden of a single-payer system, free at the point of entry, be unacceptable, but total costs would increase even more because demand would increase, administrative costs would go up, and Americans won't wait for services they want and need.

That's why we must lead, and provide mechanisms to deal with the faults in our system with rational, do-able solutions that permit incremental implementation with the highest priority problems addressed first — solutions that retain the strengths of our current system: centers of excellence, an investment in research, pluralism, and free choice. We must deal with the access problem with the AMA's proposal — Health Access America, or something like it. The elements of the Pepper Commission's report aren't far off.

Our proposal calls for the United States to:

1. Expand the Medicaid program to cover everyone below the regional poverty level with a decent package of benefits that is uniform across the country.
2. Increase employer-provided private insurance for the two thirds of our uninsured who are employed. Phase it in and give tax

credits to small business.

3. Set risk pools in place in each state to cover the uninsurable.
4. Provide catastrophic coverage and basic preventive services as part of a basic benefit package.
5. Establish innovative approaches to provide long-term care. These may include provisions for asset protection such as those proposed by Congressman Kennealy, tax law changes to permit IRAs for health (to be drawn down for long-term care), and tax deductibility of premiums paid for long-term care insurance.

Cost containment dominates our thinking and it should. Here are some strategies that should be supported:

1. Appropriate cost sharing for those who are able to pay. This is the most important factor in rationalizing demand for services.
2. We should fully implement the physician payment reform legislation passed last year — a budget-neutral RBRVS. Everyone knows that some inequities exist. The public focuses on only the high side. We can insist on fairness and achieve fairness if we work together.
3. We must reduce administrative costs. To do this, we should:
  - Eliminate utilization management that doesn't work. Some second opinion programs simply increase costs.
  - Revise conditions of participation for hospitals and eliminate nonsense such as co-signatures on the record and make-work committees; and,
  - We should examine every administrative action against tests of relevance and cost-effectiveness.



## Doctor Nelson Responds to Pepper Commission

4. Cut defensive medicine costs — I don't set out each day to increase costs, but if I'm worried about "failure to diagnose" liability, cost consciousness goes out the window and I order what I need to support my clinical decision if I'm later challenged in court.
5. Let's get the Justice Department and FTC off our backs so we can adjudicate fees, and present ourselves as willing and able to act on patient complaints.
6. Support effectiveness research and get a better understanding of geographic variations, their reasons, and where, within the range, the optimal lies.
7. Practice parameters are strategies to assist physicians in better and most cost effective patient care. They promise to enhance value. Some will reduce unnecessary care. If incorporated as part of a continuous improvement process, they should enhance quality.
8. We must work toward better use of nursing resources in the hospital. Nurse salaries are an increasing component of hospital costs. And nurses should be doing tasks that require their level of skill and training.
9. We, as health workers and as a nation, must invest in and place more emphasis on health promotion and disease prevention, including better patient education — beginning with health education in the schools, including sex education at the right time. Tobacco ads make no sense. How can we justify spending \$3 billion a year to promote a product that kills 350,000 of our people each year?

**T**o summarize —

1. Our system has serious problems, along with the admirable strengths that serve 87% of us well. We must confront and correct the problems.
2. We must set our priorities and fulfill our promise to the poor, and increase coverage at the work site.
3. It will require money to do it, but nowhere near as much as it would cost to provide a single payer system free at the point of access.
4. Now is the time to do what needs to be done. You are part of the process of building consensus that will get it done.

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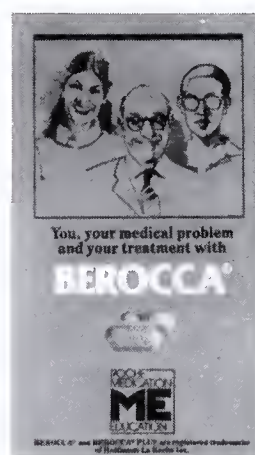
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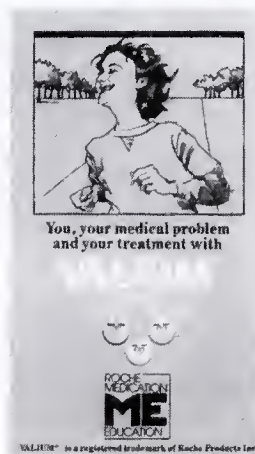
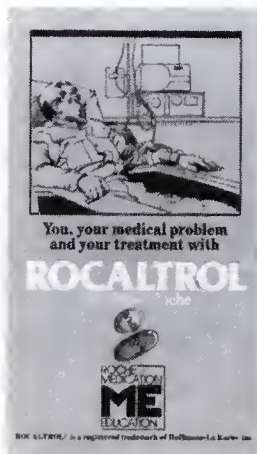
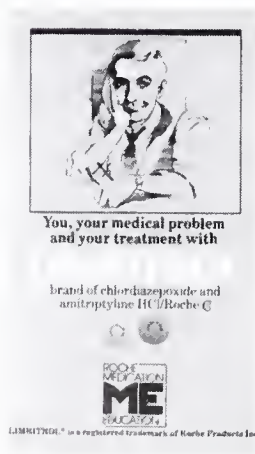
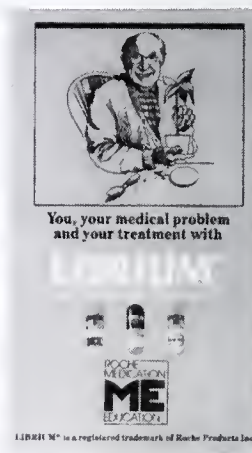
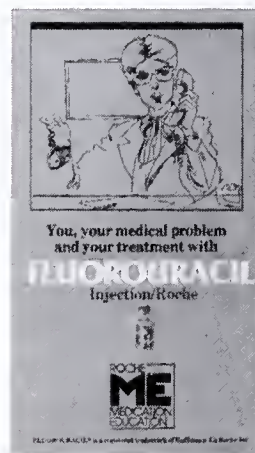
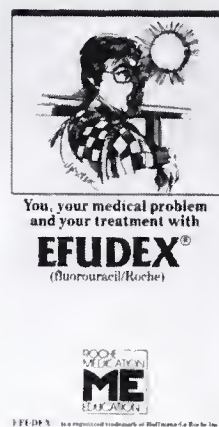
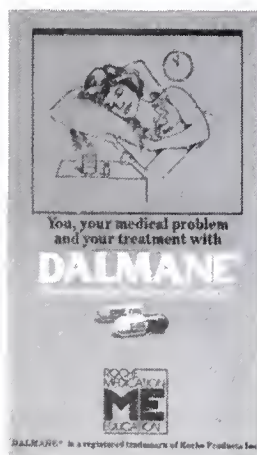


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# VASOTEC<sup>®</sup>

## (ENALAPRIL MALEATE) MSD

VASOTEC is available in 2.5-mg, 5-mg, 10-mg, and 20-mg tablet strengths.

**Contraindications:** VASOTEC<sup>®</sup> (Enalapril Maleate, MSO) is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor.

**Warnings: Angioedema:** Angioedema of the face, extremities, lips, tongue, glottis, and/or larynx has been reported in patients treated with ACE inhibitors, including VASOTEC. In such cases, VASOTEC should be promptly discontinued and appropriate therapy and monitoring should be provided until complete and sustained resolution of signs and symptoms has occurred. In instances where swelling has been confined to the face and lips, the condition has generally resolved without treatment, although antihistamines have been useful in relieving symptoms. Angioedema associated with laryngeal edema may be fatal. **Where there is involvement of the tongue, glottis, or larynx likely to cause airway obstruction, appropriate therapy, e.g., subcutaneous epinephrine solution 1:1000 (0.3 mL to 0.5 mL) and/or measures necessary to ensure a patent airway, should be promptly provided.** (See ADVERSE REACTIONS.)

**Hypotension:** Excessive hypotension is rare in uncomplicated hypertensive patients treated with VASOTEC alone. Patients with heart failure given VASOTEC commonly have some reduction in blood pressure, especially with the first dose, but discontinuation of therapy for continuing symptomatic hypotension usually is not necessary when dosing instructions are followed, caution should be observed when initiating therapy (See DOSAGE AND ADMINISTRATION). Patients at risk for excessive hypotension, sometimes associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death, include those with the following conditions or characteristics: heart failure, hyponatremia, high-dose diuretic therapy, recent intensive diuresis or increase in diuretic dose, renal dialysis, or severe volume and/or salt depletion of any etiology. It may be advisable to eliminate the diuretic (except in patients with heart failure), reduce the diuretic dose, or increase salt intake cautiously before initiating therapy with VASOTEC in patients at risk for excessive hypotension who are able to tolerate such adjustments (See PRECAUTIONS, Drug Interactions and ADVERSE REACTIONS). In patients at risk for excessive hypotension, therapy should be started under very close medical supervision and such patients should be followed closely for the first two weeks of treatment and whenever the dose of enalapril and/or diuretic is increased. Similar considerations may apply to patients with ischemic heart disease or cardiovascular disease in whom an excessive fall in blood pressure could result in a myocardial infarction or cerebrovascular accident.

If excessive hypotension occurs, the patient should be placed in the supine position and, if necessary, receive an intravenous infusion of normal saline. A transient hypotensive response is not a contraindication to further doses of VASOTEC, which usually can be given without difficulty once the blood pressure has stabilized. If symptomatic hypotension develops, a dose reduction or discontinuation of VASOTEC or concomitant diuretic may be necessary.

**Neutropenia/Agranulocytosis:** Another ACE inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression, rarely in uncomplicated patients but more frequently in patients with renal impairment, especially if they also have a collagen vascular disease. Available data from clinical trials of enalapril are insufficient to show that enalapril does not cause agranulocytosis at similar rates. Foreign marketing experience has revealed several cases of neutropenia or agranulocytosis in which a causal relationship to enalapril cannot be excluded. Periodic monitoring of white blood cell counts in patients with collagen vascular disease and renal disease should be considered.

**Fetal/Neonatal Morbidity and Mortality:** ACE inhibitors, including VASOTEC, can cause fetal and neonatal morbidity and mortality when administered to pregnant women.

Enalapril crosses the human placenta. When ACE inhibitors have been used during the second and third trimesters of pregnancy, there have been reports of hypotension, renal failure, skull hypoplasia, and/or death in the newborn. Oligohydramnios has also been reported, presumably representing decreased renal function in the fetus, limb contractures, craniofacial deformities, hypoplastic lung development and intrauterine growth retardation have been reported in association with oligohydramnios. Patients who do require ACE inhibitors during the second and third trimesters of pregnancy should be apprised of the potential hazards to the fetus, and frequent ultrasound examinations should be performed to look for oligohydramnios. If oligohydramnios is observed, VASOTEC should be discontinued unless it is considered life-saving for the mother.

Other potential risks to the fetus/neonate exposed to ACE inhibitors include: intrauterine growth retardation, prematurity, patent ductus arteriosus, fetal death has also been reported. It is not clear, however, whether these reported events are related to ACE inhibition or the underlying maternal disease. It is not known whether exposure limited to the first trimester can adversely affect fetal outcome.

Infants exposed *in utero* to ACE inhibitors should be closely observed for hypotension, oliguria, and hyperkalemia. If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion.

Enalapril has been removed from the neonatal circulation by peritoneal dialysis and theoretically may be removed by exchange transfusion, although there is no experience with the latter procedure.

There was no fetotoxicity or teratogenicity in rats treated with up to 200 mg/kg/day of enalapril (333 times the maximum human dose). Fetotoxicity, expressed as a decrease in average fetal weight, occurred in rats given 1200 mg/kg/day of enalapril, but did not occur when these animals were supplemented with saline. Enalapril was not teratogenic in rabbits. However, maternal and fetal toxicity occurred in some rabbits at doses of 1 mg/kg/day or more. Saline supplementation prevented the maternal and fetal toxicity seen at doses of 3 and 10 mg/kg/day but not at 30 mg/kg/day (50 times the maximum human dose).

If VASOTEC is used during pregnancy or if the patient becomes pregnant while taking VASOTEC, the patient should be apprised of the potential hazards to the fetus.

**Precautions: General Impaired Renal Function:** As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with ACE inhibitors, including VASOTEC, may be associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine were observed in 20% of patients. These increases were almost always reversible upon discontinuation of enalapril and/or diuretic therapy. In such patients, renal function should be monitored during the first few weeks of therapy.

Some patients with hypertension or heart failure with no apparent preexisting renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when VASOTEC has been given concomitantly with a diuretic. This is more likely to occur in patients with preexisting renal impairment. Dosage reduction and/or discontinuation of the diuretic and/or VASOTEC may be required.

**Evaluation of patients with hypertension or heart failure should always include assessment of renal function.** (See DOSAGE AND ADMINISTRATION.)

**Hyperkalemia:** Elevated serum potassium (> 5.7 mEq/L) was observed in approximately 1% of hypertensive patients in clinical trials. In most cases these were isolated values which resolved despite continued therapy. Hyperkalemia was a cause of discontinuation of therapy in 0.28% of hypertensive patients. In clinical trials in heart failure, hyperkalemia was observed in 3.8% of patients, but was not a cause for discontinuation.

Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements, and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with VASOTEC. (See Drug Interactions.)

**Cough:** Cough has been reported with the use of ACE inhibitors. Characteristically, the cough is nonproductive, persistent and resolves after discontinuation of therapy. ACE inhibitor-induced cough should be considered as part of the differential diagnosis of cough.

**Surgery/Anesthesia:** In patients undergoing major surgery or during anesthesia with agents that produce hypotension, enalapril may block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

**Information for Patients: Angioedema:** Angioedema, including laryngeal edema, may occur especially following the first dose of enalapril. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to take no more drug until they have consulted with the prescribing physician.

**Hypotension:** Patients should be cautioned to report lightheadedness, especially during the first few days of therapy. If

actual syncope occurs, the patients should be told to discontinue the drug until they have consulted with the prescribing physician.

All patients should be cautioned that excessive perspiration and dehydration may lead to an excessive fall in blood pressure because of reduction in fluid volume. Other causes of volume depletion such as vomiting or diarrhea may also lead to a fall in blood pressure, patients should be advised to consult with the physician.

**Hyperkalemia:** Patients should be told not to use salt substitutes containing potassium without consulting their physician.

**Neutropenia:** Patients should be told to report promptly any indication of infection (e.g., sore throat, fever) which may be a sign of neutropenia.

**NOTE:** As with many other drugs, certain advice to patients being treated with enalapril is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects.

**Drug Interactions: Hypotension: Patients on Diuretic Therapy:** Patients on diuretics and especially those in whom diuretic therapy was recently instituted may occasionally experience an excessive reduction of blood pressure after initiation of therapy with enalapril. The possibility of hypotensive effects with enalapril can be minimized by either discontinuing the diuretic or increasing the salt intake prior to initiation of treatment with enalapril. If it is necessary to continue the diuretic, provide close medical supervision after the initial dose for at least two hours and until blood pressure has stabilized for at least an additional hour (See WARNINGS and DOSAGE AND ADMINISTRATION).

**Agents Causing Renin Release:** The antihypertensive effect of VASOTEC<sup>®</sup> (Enalapril Maleate, MSO) is augmented by antihypertensive agents that cause renin release (e.g., diuretics).

**Other Cardiovascular Agents:** VASOTEC has been used concomitantly with beta-adrenergic-blocking agents, methyldopa, nitrates, calcium-blocking agents, hydralazine, prazosin, and digoxin without evidence of clinically significant adverse interactions.

**Agents Increasing Serum Potassium:** VASOTEC attenuates potassium loss caused by thiazide-type diuretics. Potassium-sparing diuretics (e.g., spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes may lead to significant increases in serum potassium. Therefore, if concomitant use of these agents is indicated because of demonstrated hypokalemia, they should be used with caution and with frequent monitoring of serum potassium. Potassium-sparing agents should generally not be used in patients with heart failure receiving VASOTEC.

**Lithium:** Lithium toxicity has been reported in patients receiving lithium concomitantly with drugs which cause elimination of sodium, including ACE inhibitors. A few cases of lithium toxicity have been reported in patients receiving concomitant VASOTEC and lithium and were reversible upon discontinuation of both drugs. It is recommended that serum lithium levels be monitored frequently if enalapril is administered concomitantly with lithium.

**Pregnancy: Pregnancy Category D.** See WARNINGS, Fetal/Neonatal Morbidity and Mortality.

**Nursing Mothers:** Enalapril and enalaprilat are detected in human milk in trace amounts. Caution should be exercised when VASOTEC is given to a nursing mother.

**Pediatric Use:** Safety and effectiveness in children have not been established.

**Adverse Reactions:** VASOTEC has been evaluated for safety in more than 10,000 patients, including over 1000 patients treated for one year or more. VASOTEC has been found to be generally well tolerated in controlled clinical trials involving 2987 patients.

**HYPERTENSION:** The most frequent clinical adverse experiences in controlled trials were: headache (5.2%), dizziness (4.3%), and fatigue (3%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in controlled clinical trials were: diarrhea (1.4%), nausea (1.4%), rash (1.4%), cough (1.3%), orthostatic effects (1.2%), and asthenia (1.1%).

**HEART FAILURE:** The most frequent clinical adverse experiences in both controlled and uncontrolled trials were: dizziness (7.9%), hypotension (6.7%), orthostatic effects (2.2%), syncope (2.2%), cough (2.2%), chest pain (2.1%), and diarrhea (2.1%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in both controlled and uncontrolled clinical trials were: fatigue (1.8%), headache (1.8%), abdominal pain (1.6%), asthenia (1.6%), orthostatic hypotension (1.6%), vertigo (1.6%), angina pectoris (1.5%), nausea (1.3%), vomiting (1.3%), bronchitis (1.3%), dyspnea (1.3%), urinary tract infection (1.3%), rash (1.3%), and myocardial infarction (1.2%).

Other serious clinical adverse experiences occurring since the drug was marketed or adverse experiences occurring in 0.5% to 1% of patients with hypertension or heart failure in clinical trials in order of decreasing severity within each category:

**Cardiovascular:** Cardiac arrest, myocardial infarction or cerebrovascular accident, possibly secondary to excessive hypotension in high-risk patients (see WARNINGS, Hypotension), pulmonary embolism and infarction, pulmonary edema, rhythm disturbances including atrial tachycardia and bradycardia, atrial fibrillation; palpitation.

**Digestive:** Ileus, pancreatitis, hepatitis (hepatocellular [proven on rechallenge] or cholestatic jaundice), melena, anorexia, dyspepsia, constipation, glossitis, stomatitis, dry mouth.

**Musculoskeletal:** Muscle cramps.

**Nervous/Psychiatric:** Depression, confusion, ataxia, somnolence, insomnia, nervousness, paresthesia.

**Respiratory:** Bronchospasm, rhinorrhea, sore throat and hoarseness, asthma, upper respiratory infection.

**Skin:** Exfoliative dermatitis, toxic epidermal necrolysis, Stevens-Johnson syndrome, herpes zoster, erythema multiforme, urticaria, pruritus, alopecia, flushing, diaphoresis.

**Special Senses:** Blurred vision, taste alteration, anosmia, tinnitus, conjunctivitis, dry eyes, tearing.

**Urogenital:** Renal failure, oliguria, renal dysfunction (see PRECAUTIONS and DOSAGE AND ADMINISTRATION), impotence.

A symptom complex has been reported which may include a positive ANA, an elevated erythrocyte sedimentation rate, arthralgia/arthritis, myalgia, fever, serositis, vasculitis, leukocytosis, eosinophilia, photosensitivity, rash, and other dermatologic manifestations.

**Angioedema:** Angioedema has been reported in patients receiving VASOTEC (0.2%). Angioedema associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis, and/or larynx occurs, treatment with VASOTEC should be discontinued and appropriate therapy instituted immediately (See WARNINGS).

**Hypotension:** In the hypertensive patients, hypotension occurred in 0.9% and syncope occurred in 0.5% of patients following the initial dose or during extended therapy. Hypotension or syncope was a cause for discontinuation of therapy in 0.1% of hypertensive patients. In heart failure patients, hypotension occurred in 6.7% and syncope occurred in 2.2% of patients. Hypotension or syncope was a cause for discontinuation of therapy in 1.9% of patients with heart failure (See WARNINGS).

**Fetal/Neonatal Morbidity and Mortality:** In infants exposed *in utero* to ACE inhibitors the following adverse experiences have been reported: Fetal and neonatal death, renal failure, hypoplastic lung development, hypotension, hyperkalemia, skull hypoplasia, limb contractures, craniofacial deformities, intrauterine growth retardation, prematurity and patent ductus arteriosus. (See WARNINGS, Fetal/Neonatal Morbidity and Mortality.)

**Clinical Laboratory Test Findings: Serum Electrolytes:** Hyperkalemia (see PRECAUTIONS), hyponatremia.

**Creatinine, Blood Urea Nitrogen:** In controlled clinical trials, minor increases in blood urea nitrogen and serum creatinine, reversible upon discontinuation of therapy, were observed in about 0.2% of patients with essential hypertension treated with VASOTEC alone. Increases are more likely to occur in patients receiving concomitant diuretics or in patients with renal artery stenosis (See PRECAUTIONS). In patients with heart failure who were also receiving diuretics with or without digitalis, increases in blood urea nitrogen or serum creatinine, usually reversible upon discontinuation of VASOTEC and/or other concomitant diuretic therapy, were observed in about 11% of patients. Increases in blood urea nitrogen or creatinine were a cause for discontinuation in 1.2% of patients.

**Hemoglobin and Hematocrit:** Small decreases in hemoglobin and hematocrit (mean decreases of approximately 0.3 g% and 1.0 vol%, respectively) occur frequently in either hypertension or heart failure patients treated with VASOTEC but are rarely of clinical importance unless another cause of anemia coexists. In clinical trials, less than 0.1% of patients discontinued therapy due to anemia.

**Other (Causal Relationship Unknown):** In marketing experience, rare cases of neutropenia, thrombocytopenia, and bone marrow depression have been reported. A few cases of hemolysis have been reported in patients with G6PD deficiency.

**Liver Function Tests:** Elevations of liver enzymes and/or serum bilirubin have occurred.

For more detailed information, consult your MSD Representative or see Prescribing Information, Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, PA 19486 J9V561R2(824)

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# Respiratory Failure Associated With Myasthenia Gravis

Thomas M. Roy, MD; Jerome F. Walker, PhD, RRT; Jeff R. Farrow, MD

*Dysphagia and respiratory muscle weakness are the two most potentially dangerous findings in patients with neuromuscular disease because they predispose to aspiration pneumonia and respiratory failure. Myasthenia gravis is unique among the neuromuscular disorders for the variety of exacerbating factors that may lead to such clinical deterioration. While the major cause of ventilatory failure remains intensification of the underlying autoimmune process, well intentioned therapy may also lead to situations that necessitate ventilatory support. This report describes a patient with myasthenia gravis and respiratory failure and reviews the various etiologies of pulmonary dysfunction that are associated with the natural course of this disease and its treatment.*

## Introduction

The diagnosis of myasthenia gravis (MG) is suggested by a history of muscle weakness which is worsened by exercise and improved with rest.

The suspicion of MG is reinforced when the electromyogram shows a characteristic decrement in the muscle action potential with repetitive stimulation and when an improvement in muscle power can be demonstrated after the administration of an anticholinesterase drug such as edrophonium. Confirmation of MG is accomplished by demonstrating the anti-acetylcholine receptor antibody (anti-AChR antibody) in the patient's plasma. It is this IgG anti-AChR antibody, through complement-mediated lysis, which causes increased breakdown of the acetylcholine receptors on the postjunctional membrane of the neuromuscular junction. The autoimmune antibody produced by the thymus can be demonstrated in 90% of MG patients with generalized symptoms.<sup>1</sup> The neuromuscular junction is eventually depleted of acetylcholine receptors. The characteristic fatigable muscle weakness ensues unless the concentration of acetylcholine at the postsynaptic membrane can be increased. Anticholinesterase

agents delay the degradation of acetylcholine by blocking the activity of cholinesterase.

Because some muscle groups may be affected more than others, the expression of this autoimmune disorder may vary from mild ocular muscle dysfunction to generalized muscle weakness. Although advances in the understanding and therapy of MG have reduced the mortality rate from 14% in 1965 to 7% in 1985,<sup>2</sup> respiratory failure remains a common cause of death.<sup>3</sup>

Ventilatory failure has been reported as the initial presentation of MG when selective weakness involved the diaphragm<sup>4, 5</sup> or the vocal cords,<sup>6, 7</sup> but pulmonary dysfunction more commonly occurs in the patient previously diagnosed with MG.<sup>2</sup> As interference with respiratory muscle function may be precipitated in these patients by a variety of factors, including anticholinesterase therapy, we provide a review of respiratory failure associated with MG introduced by a case report.

## Case Report

S.C., a 37-year-old female, presented to the emergency room 6 days after the onset of an upper respiratory infection because of progressive weakness, dysphagia, dyspnea and respiratory failure. A diagnosis of myasthenia gravis had been confirmed 6 years earlier. She had refused thymectomy but was compliant with a regimen that consisted of pyridostigmine 60 mg every 4 hours and prednisone 15 mg each day. Limbitrol was also among the patient's admitting medications and had been prescribed for anxiety.

Her past history was significant for childhood poliomyelitis that left her with residual right lower extremity weakness. Additional problems included obesity and glucose intolerance aggravated by prednisone therapy.

The patient's rectal temperature was 99°F. Her pulse rate was 102 BPM in a regular rhythm without ectopy. Blood pressure was 116/80 torr. The patient's respirations were assisted by mechanical ventilation at 14 breaths per minute. Extraocular range of motion was normal without

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## Myasthenia Gravis

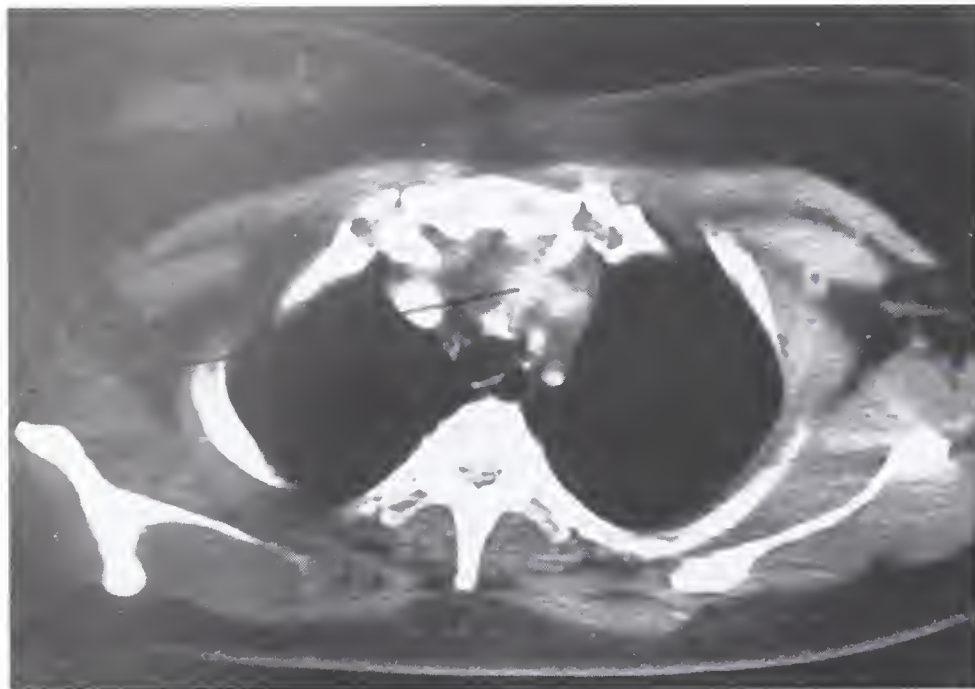


Fig 1 — CT scan of the chest shows thymic enlargement.

ptosis or eyelid weakness. The cardiovascular examination was unremarkable. Bilateral breath sounds were present with rhonchi in the right base. Muscle strength of the upper and lower extremities was estimated at 3/5. Deep tendon reflexes were normal. The right gastrocnemius muscle showed atrophy from childhood poliomyelitis.

The patient's admitting laboratory tests were unremarkable except for the arterial blood gas analysis which measured the PaO<sub>2</sub> at 42 torr, the PaCO<sub>2</sub> at 66 torr, and the pH at 7.14. A portable chest radiograph demonstrated an infiltrate in the right lower lobe with a small pleural effusion blunting the right costophrenic angle. Her sputum contained Gram positive diplococci.

Erythromycin was administered intravenously for the presumed right lower lobe pneumonia. Her maintenance medications, including the anticholinesterase agent, were discontinued for 48 hours during full ventilatory support to eliminate the possibility of a cholinergic crisis. On the third hospital day, neostigmine was started by the intramuscular route. Approximately 12 hours after the initial dose, the patient demonstrated marked improvement of ventilatory and extremity strength. Weaning parameters were found to be excellent and she was extubated. With continued administration of neostigmine, the patient ventilated well without distress for approximately 6 hours. Oxy-

genation subsequently deteriorated as the patient developed difficulty dealing with her oral and respiratory secretions. The patient was reintubated and returned to ventilatory support. Collapse of the left lower lung was confirmed by physical examination and chest radiograph. Reexpansion of the left lung was accomplished after pooled secretions were removed by bedside bronchoscopy. After proper titration of the anticholinesterase medication, reinstitution of corticosteroids, and four sessions of plasmapheresis, the patient was again removed from respiratory support. Pulmonary toilet was continued while the patient remained intubated and on supplemental oxygen. After an additional 48 hours, the patient had an efficient cough and could manage her secretions. Successful extubation was accomplished.

On subsequent pulmonary testing, the patient demonstrated a mild restrictive defect and a normal flow-volume loop. An area of thymic enlargement, not consistent with thymoma, was found on CT scan of the chest (Figure). A 90 gram thymus, showing the germinal centers characteristic of thymic hyperplasia, was removed by a transternal approach on the 20th hospital day.

The patient had an unremarkable postoperative course with eventual discontinuation of anticholinesterase medication. She was discharged on daily prednisone 10 days after surgery. At 3 month follow-up, she requires only 10 mg of prednisone on alternate days and remains asymptomatic.

## Discussion

Respiratory failure associated with myasthenia gravis is frequently classified according to the anticipated acetylcholine activity at the neuromuscular junction. A "myasthenic crisis" refers to severe weakness resulting from a relative depletion of effective acetylcholine activity at the postsynaptic membrane. Such clinical deterioration is commonly seen in the first few years after diagnosis when spontaneous worsening of the disease is anticipated.<sup>2</sup> Alternatively a myasthenic crisis can be associated with an intended or inadvertent decrease in anticholinesterase medication.

Several features of MG make adequate titration of anticholinesterase medication extremely difficult. The severity of an individual's weakness commonly varies from morning to evening and from day to day. These expected fluctuations are

compounded as psychological stress, menses, pregnancy, infection, and surgical procedures may cause precipitous worsening of symptoms.<sup>3</sup>

Other autoimmune disorders such as rheumatoid arthritis, pernicious anemia, and lupus erythematosus occur in association with MG often enough to suggest more than chance occurrence. Also, thyroid dysfunction occurs in 10% of MG patients at sometime during the course of their lifetime. Poor control of these disorders can promote a myasthenic crisis. Since these diseases are traditionally associated with fatigue and weakness, their presence obviously complicates the proper interpretation of symptoms and may lead to inappropriate changes in the dosage of anticholinesterase.

The effects of medications must also be considered. Procainamide, quinidine, tetracycline, and aminoglycosides may potentially interfere with neuromuscular transmission. The use of diuretics may cause electrolyte depletion that may promote muscle weakness. The institution and use of corticosteroids is particularly difficult as this drug alters the dose requirement of the anticholinesterase agent. The MG patient often experiences unpredictable muscle responses when anxiolytics or antidepressants are prescribed. Finally, the potential for aspiration of increased gastric secretions associated with the use of an anticholinesterase medication must be acknowledged.

The term "cholinergic crisis" denotes the condition of severe increased muscle weakness associated with the depolarizing blockade caused by a relative excess of acetylcholine at the neuromuscular junction. Clinically this results from too much anticholinesterase medication and is characterized by muscarinic side effects such as abdominal cramps, excessive salivation, and respiratory and bulbar muscle weakness. To minimize desensitization of the postsynaptic membrane from excessive accumulation of acetylcholine at the neuromuscular junction, most patients are dosed in a manner that maintains a slightly myasthenic state. The numerous factors that may cause wide fluctuations in medication requirements, however, place the MG patient in continuous jeopardy of a cholinergic crisis.

A "brittle crisis" is said to occur when the patient's response to anticholinergic agents is inconsistent and the patient alternates between myasthenic and cholinergic crises. The severity of the muscle weakness is no less severe. The brittle patient requires additional interventions to avoid the onset of respiratory failure.

A remission will occur in approximately 80% of MG patients if steroids can be tolerated. Aggressive initial treatment, however, may result in muscle weakness and respiratory failure from transient steroid myopathy and/or a direct interaction with the anticholinesterase agent. This can be avoided by starting with a low dose on alternate days followed by a gradual increase to a maximum of 120 mg on alternate days. Maintenance therapy can then be determined by slow reduction to the minimum dose that maintains improvement.

Azathioprine has also been successful, but the improvement in muscle strength is considerably slower than with corticosteroid therapy. Remission may take as long as one year to accomplish. Used in combination, the steroids may produce a rapid improvement and azathioprine can maintain long term remission and allow tapering of the corticosteroid. The side effects inherent in the prolonged use of these agents generates a reluctance to employ this therapy in the younger age group, especially in females of child-bearing age.

Surgical management of myasthenia gravis in selected patients has been a standard mode of therapy since symptomatic improvement was first reported by Blalock in 1939.<sup>8</sup> Presumably the antigenic stimulus in the gland that perpetuates anti-AChR antibody production is removed. During the months after surgery, the concentration of anti-AChR antibodies gradually decline.<sup>9</sup>

The patients most likely to show a positive response after thymectomy are those who have a thymoma and those under the age of 50 years whose thymus shows hyperplasia. In patients over the age of 60 without thymomas, thymectomy is generally avoided due to increased surgical risks and diminished amounts of thymic tissue. The majority of patients with MG develop thymic hyperplasia, characterized by an increase in germinal centers in the medulla of the thymus. Actual thymoma occurs in only 10% of patients. Regardless of whether a thymoma is found, improvement occurs in 70% of patients with MG who have a thymectomy. Complete remission may occur in as many as 40% of cases.<sup>10</sup> The expected immediate benefit attributable to thymectomy is better control of the disease with a reduced requirement for medication after recovery from surgery. The positive results of a thymectomy may not always occur immediately and it may take up to several years to determine the total benefit to the individual.



## Myasthenia Gravis

The postoperative course of the thymectomy patient is frequently accompanied by ventilator dependency. Investigators have reported that advanced age, a preoperative vital capacity below 2 liters, and the presence of a thymoma are risk factors for prolonged mechanical ventilation.<sup>11</sup> Plasmapheresis and treatment with steroids can potentially improve the preoperative status of the patient and reduce the postoperative ventilator requirements.<sup>12</sup> Plasma exchange has been shown to effectively reduce anti-AChR antibody concentrations and allow regeneration of acetylcholine receptors.<sup>13</sup> The clinical improvement occurs within a few days but lasts only 3 to 4 weeks. While cholinesterase inhibitors are usually withheld in the first 24 hours after surgery because of the patient's reduced needs and vulnerability to cholinergic toxicity, others have suggested that the postoperative ventilator dependency can be lessened if reinstitution of cholinesterase inhibitors is not delayed beyond the second postoperative day.<sup>9</sup>

Other treatments which include gamma globulin, antilymphocyte antiserum, splenic radiation, and cyclophosphamide have been used too infrequently to accurately evaluate their clinical utility at this juncture.

When treatment fails to prevent a crisis, the clinician must protect the patient from respiratory arrest or aspiration pneumonia by timely intubation and mechanical ventilation. A study of pulmonary mechanics suggests that a vital capacity of 15cc/kg of body weight and a negative inspiratory force of 30 cm H<sub>2</sub>O are necessary for the maintenance of unassisted spontaneous ventilation. Measurement of vital capacity remains the most useful functional monitor of the evolution of the myasthenic process and its response to therapy. The restriction of lung volume far exceeds that expected for the clinical degree of peripheral muscle weakness and must be measured serially.<sup>14</sup> Intubation and mechanical ventilation are recommended when the vital capacity or negative inspiratory force fall below the above mentioned guidelines. Deterioration of arterial blood gas values is a late indication of distress and a reminder that the opportunity for controlled elective intervention has been missed.

The patient with MG is rarely difficult to ventilate since lung compliance and airway resistance are usually normal. Because high ventilating pressures are not necessary, barotrauma is an infrequent problem. PEEP is rarely needed to achieve oxygenation unless a serious pulmonary infection or sepsis is the precipitating cause of the crisis.

Chest physiotherapy and safe endotracheal suctioning are critical.

In contrast to respiratory failure due to many other neuromuscular diseases, mean time on the ventilator is only 8 days.<sup>3</sup> This duration of mechanical ventilation can be achieved during the period in which high-volume, low-pressure cuffed endotracheal tubes may be safely tolerated. Early tracheostomy is not advised for most MG patients who require ventilatory support. On the other hand, tracheostomy may be necessary for the rare MG patient who requires more prolonged ventilatory support (beyond 21 days) or for the patient liberated from the ventilator who cannot regain sufficient muscle strength to spontaneously clear tracheal secretions. Adequate pulmonary hygiene may then be maintained with tracheal suctioning at home on a chronic basis.

The MG patient may have unpredictable responses to a number of medications commonly used during intensive care. It is essential to avoid those medications which may interfere with neuromuscular transmission such as succinylcholine, morphine, quinidine, procainamide, tetracycline, and aminoglycosides. A special problem area in the nursing care of the MG patient is the decision to address stress reduction with an anxiolytic or sleep deprivation with hypnotic agents.

Plasmapheresis is recommended for the patient with respiratory failure who is refractory to conventional anticholinesterase/steroid therapy. The immediate but temporary improvement often allows sufficient respiratory muscle strength to permit discontinuation of mechanical ventilation and eventual extubation.<sup>13</sup>

The edrophonium test is an essential bedside test in the intensive care unit. It can help the physician distinguish if the patient's respiratory failure has a myasthenic or cholinergic origin. Serial testing allows accurate titration of the anticholinesterase at a time during critical care when drug requirements are expected to change from resolution of infection, plasmapheresis, operative procedures, or the institution of corticosteroids. Two to five milligrams of edrophonium are administered intravenously after pretreatment with 0.3 to 0.6 mg of intravenous atropine sulfate. If the patient is myasthenic, a marked improvement in muscle power occurs within 30 seconds and lasts for approximately 2 to 3 minutes. For the patient in respiratory failure this improvement can be easily documented by an observed increase in the vital capacity.

As a general rule the patient may be removed from mechanical ventilatory support when the

previously cited values for vital capacity and negative inspiratory force are restored. As illustrated by our case report, successful weaning from ventilatory support is not justification for immediate extubation. Usually the artificial airway must remain in place 1 to 2 days longer to insure that the patient can adequately handle respiratory secretions. The presence of an adequate gag reflex, an effective cough response, and the amount of secretions are all variables influencing the timing of extubation.

Following successful recovery from respiratory failure associated with MG, the patient should have pulmonary function tests that assess the inspiratory limb by flow-volume loop. Several cases of vocal cord paresis and laryngeal muscle weakness contributing to respiratory failure have now been reported.<sup>6,7</sup> A baseline assessment will help the clinician recognize this unusual cause of pulmonary dysfunction as well as identify any significant residual from earlier endotracheal intubation.

With early diagnosis and proper therapy most patients with MG should be able to lead full and productive lives. The physician must be alert to the numerous factors with the potential of exacerbating the disorder and leading to respiratory failure. While the clinical manifestations of the seriously ill patient with MG can vary widely, easily performed bedside measurements of vital capacity and negative inspiratory force allow the clinician to recognize the development of respiratory failure and make timely management decisions.

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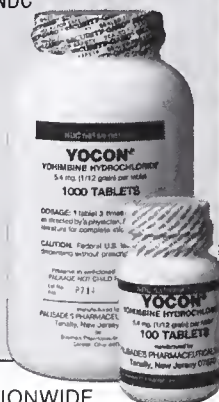
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# Extraperitoneal Approach to Aorto-Iliac Femoral-Popliteal Arterial Occlusive Disease: Rationale and Results

Sam F. Yared, MD; John C. Norman, MD; Allan M. Lansing, MD, PhD

## Introduction

**T**wenty-five patients underwent aorto-iliac femoral-popliteal bypass grafting procedures utilizing an extraperitoneal (EP) approach. They were compared to 25 patients in whom a transperitoneal (TP) approach was used. Decreases in post-operative pain, atelectasis, and ileus were noted with the EP approach. Considerations predicting and supporting these findings are reviewed.

With advancing age, arterial occlusive disease of the infra-renal aorta and its branches is not uncommon. Reconstructive procedures with arterial prostheses are readily accomplished.<sup>1, 2</sup> We elected to compare the incidence of common complications: (1) prolonged pain; (2) atelectasis/pneumonia; (3) gastrointestinal ileus and morbidity in general, as reflected by hospital stay in two groups of patients of comparable ages and infra-renal vascular disease processes. In one group a transperitoneal (TP) approach was used. In the second, an extraperitoneal (EP) approach was used. We reasoned that the latter, in which the parietal peritoneum remains intact, would result in less morbidity.

## Considerations and Predictions

The peritoneum<sup>3</sup> is the largest and most complexly arranged serous membrane in the body. In the male, it consists of a closed sac, a portion of which lines the abdominal wall, as the remainder is reflected over the contained viscera. In the female, the lateral ends of the uterine tubes open into the peritoneal cavity. The portion which lines the abdominal wall or parietes is the parietal portion of the peritoneum; that which is reflected over the contained viscera constitutes the visceral portion.

When the parietal peritoneum is divided, pain is the most common symptom, mediated through the intercostal branches of spinal nerves 5 through 11 which constitute its innervation. Other sensory nerve pathways from the abdomen include both spinal nerves and the autonomic nervous system. The phrenic nerve provides sensory innervation of the visceral peritoneum and the abdominal and pelvic organs. Other sensory innervation of the abdominal and pelvic organs is provided by the autonomic nervous system.

The primary causes of postoperative atelectasis are hypoventilation, recumbency and ineffective coughing in patients with pain.<sup>4-7</sup> It most frequently follows intrathoracic, upper and mid-abdominal surgery. Of all postoperative complications, atelectasis and pneumonia are the most common. A Mayo Clinic report<sup>8</sup> on surgery of the upper gastrointestinal tract noted that 25% of the hospital deaths were due to pneumonia. Moersch<sup>9</sup> found atelectasis in 10% of operations on the thorax, mid or upper abdomen and in 4% of operations on the lower abdomen. Similarly, Stringer<sup>10</sup> found that 26 of 55 patients showed abnormal chest x-ray signs after gastrectomy. Of these, 13 had signs of partial or massive atelectasis. In a review of 300 consecutive patients, Clendon and Pygott<sup>11</sup> found that 38% of the abdominal group and only 2.7% of the nonabdominal group showed evidence of respiratory complications. Thoren<sup>12</sup> found pulmonary changes in 41.9% of a carefully studied group of patients subjected to biliary tract surgery. Clendon and Pygott<sup>11</sup> extensively reviewed several series to point out the greater number of pulmonary complications of upper abdominal surgery versus lower abdominal surgery, and the increasing incidences of pulmonary complications as older patients and more complicated procedures are involved. Kurzweg<sup>13</sup> summarized the incidence of postop-

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## Aorto-Iliac Femoral-Popliteal Arterial Occlusive Disease



**Fig 1 — Extraperitoneal approach to infra-renal abdominal aorta. Proximal aorta to right, distal to left. View from left side of patient. Segment of aorta and inferior mesenteric artery isolated with side-biting Satinsky vascular clamp. Linear aortotomy to be fashioned within the isolated segment of aorta for proximal aorto-bi-femoral graft anastomosis. Note excellent exposure obtained with EP approach.**

erative complications as averaging 2.5% to 3% of all operations, 10% to 20% in abdominal surgery, and 20% to 30% in upper abdominal surgery.

Adynamic (paralytic) ileus, of a degree, commonly follows all abdominal procedures when the peritoneum is opened. Manipulation, evisceration, and traction of the bowel are factors which determine the severity. It is thought that paralytic ileus is a protective mechanism that "splints" the gastrointestinal tract after any peritoneal or bowel injury.

Reduced to essentials, then, we reasoned that an extraperitoneal (EP) approach to infra-renal vascular occlusive lesions, would: (1) avoid entering the parietal peritoneum; (2) result, thereby,

in less post-operative pain; (3) result in less post-operative pain-related hypoventilation, recumbency and ineffective coughing, thus less atelectasis; and (4) result in less postoperative ileus. Taken together, these considerations would lead to shorter duration of hospitalization, earlier discharge, and earlier return to work. We corroborate these considerations and predictions in this report.

#### **Patients and Methods**

The extraperitoneal (EP) group consisted of 18 males and 7 females ranging from 42 to 82 years of age, with a mean of 70. These patients were

compared to a similar group of 20 males and 5 females ranging from 46 to 76 years of age, with a mean of 68 who had transperitoneal (TP) approaches. Both groups were matched by disease process involving the infra-renal aorta and its major branches.

Preoperative evaluations included history and physical examination, angiogram, vascular evaluations by two physicians and Doppler evaluations of distal pressures. The indications for surgery were: (1) claudication of less than 1 block; (2) rest pain; and (3) ischemic ulceration.

### Technique

The patients were placed in the supine position with a 10-15° elevation of the thoraco-lumbar region on the involved side. An oblique incision was made from near the midline to the flank between the costal margin and the iliac crest. The external oblique muscle and its aponeurosis were divided along with the posterior sheath of the rectus abdominis. The internal oblique and transversus abdominis muscles were divided, care being taken not to injure the 11th or 12th dorsal nerves. On occasions, the rectus muscle was divided to enhance medial exposure. The parietal peritoneum was dissected from the abdominal wall, displacing the ureter forward, until exposure of the aorta and its bifurcation was obtained. Proximal control was achieved (Fig 1). Thereafter, through vertical infra-inguinal groin incisions, the common femoral arteries and branches were exposed. Retro-inguinal tunnels were created anterior to the common femoral arteries with care being taken not to injure the deep circumflex iliac veins crossing the distal external iliac arteries. The inferior aspect of either or both inguinal ligaments was partially divided to prevent compression of the arterial prostheses. Prior to total body heparinization (2 mg/kg), an appropriate vascular graft was chosen and preclotted. A segment of the infra-renal aorta was isolated between vascular clamps and a linear aortotomy was fashioned for end-to-side anastomoses, or the aorta was divided, the distal segment oversewn, and the proximal segment utilized for end-to-end anastomoses, constructed with continuous sutures of 3-0 or 5-0 prolene. The vascular grafts were then clamped distal to the anastomoses and, in the instance of end-to-side anastomoses, flow was restored through the aorta and iliacs. The limbs of the arterial prostheses were brought through the retro-inguinal tunnels, parallel to the iliac ves-

**Table 1. Type of Graft Used\***

Knitted Dacron	18 patients
Microvel	3 patients
Goretex	2 patients
Vein	1 patient
Endarterectomy	1 patient

\*Extraperitoneal Approach

**Table 2. Post-Operative Results\***

Marked Improvement	18 patients
Moderate Improvement	3 patients
No Follow-up	2 patients

\*Extraperitoneal Approach

sels. The distal anastomoses to the common, superficial or profunda femoral arteries were performed at the femoral level in end-to-side fashion. Using this approach, aorto-bifemoral grafts were done in 4 patients, right aorto-femoral grafts in 4 patients, left aorto-femoral grafts in 14 patients, ilio-popliteal grafts in 2 patients, and an ilio-femoral graft in 1 patient.

Knitted Dacron grafts (Meadox Medicals, Inc, 112 Bauer Dr, Oakland, NJ, 07436) were used in 18 instances, Microvel double velour grafts (Meadox Medicals, Inc, 112 Bauer Dr, Oakland, NJ, 07436) in 3 and Gortex grafts (W.L. Gore and Assoc, Inc, Medical Products Division, Woody Mountain Facility, PO Box 900, Flagstaff, AZ, 86002) in 2. A saphenous vein was used as an ilio-popliteal bypass in 1 patient and thromboendarterectomy without a graft was done in 1 patient (Table 1). Additional procedures in 3 patients included bilateral femoral aneurysmectomy in one instance and profundoplasty in two.

### Results

Two of the patients in the extraperitoneal (EP) group had postoperative complications. One had unexplained postoperative fever which prolonged the hospital stay and one had a urinary tract infection which was treated successfully. The postoperative hospital stay ranged from 3 to 12 days with an average of 6 days. There were no instances of hemorrhage, thrombosis, or infection. The immediate patency rate was 100% and there was no mortality.

Eighteen patients experienced marked improvement of clinical symptoms. Mild to moderate improvement occurred in 3 and no follow-up was available in two (Table 2). There were no



## Aorto-Iliac Femoral-Popliteal Arterial Occlusive Disease

Table 3. Comparison of Results

	Extraperitoneal (EP)	Transperitoneal (TP)
Patients	25	25
Pain	+	+++
GI function returned	1-2 days	4-5 days
Morbidity	4%	20%
Hospital Stay	6 days	9 days

instances of atelectasis. A decrease in post-operative ileus (compared to the TP Group) was noted with a return of gastrointestinal function within 1 to 2 days. Moreover, these patients complained of less pain and, as a consequence, ambulated earlier. The overall morbidity (Table 3) was 4%, compared to a 20% instance experienced by the controls [atelectasis (1 patient), pneumonia (1 patient), severe ileus (1 patient) and hemorrhagic gastritis (1 patient)].

### Conclusions

Aorto-femoral grafting can be readily accomplished using an extraperitoneal (EP) approach. Our results confirm the occurrence of less morbidity, shortened hospital stay and imply an earlier return to work in comparison with a matched group of patients undergoing similar procedures with the transperitoneal (TP) approach. The advantages of the former have much to recommend.

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# Clarence on Cost Containment

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***“I question the government’s prudent judgment in paying for bilateral total hip replacements to save three taxi fares a week . . . ”***

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Clarence is a big, moderately overweight, cordial, talkative man. His intelligence is average and his personality magnetic. He is loving. He bears malice for no one. Never married and no issue to speak of, he lives alone in a house in Louisville. His abiding pleasures in life are raising his very considerable garden and cooking. He does not give away tomatoes. He cooks everything he grows, eats what he cooks, and gives away the ultimate product when and if he decides to. I am proud to have been beneficiary of two of these.

Clarence was brought to me by his younger cousin, Ruby White, a social worker at the youth detention center. She had a strangely plateaued cardiomyopathy. She kept a close watch on Clarence, whose only medical problem was “arthritis”: severe pain and incapacity of his hips due to advanced osteoarthritis — not enough to prevent the flourishing garden, but sufficient to precipitate recurring gastrointestinal bleeds so that he was familiar with the environs of the hospital.

Clarence began to swell. Diuresis was ineffective and he finally found our generous federal government’s dialysis program.

Meanwhile Ruby showed us why she had a cardiomyopathy and died a

prolonged and ugly death from ischemic heart disease.

Clarence’s surveillance was then undertaken by Mr Green, his friend and a true, loving Christian, who cared for Clarence.

Now, the situation deteriorates: the government informs Clarence they will no longer pay for his taxi to and from the dialysis center three times a week. Mr Green fetches Clarence to say that after these several years, Clarence now needs bilateral artificial hips so that he can attend his dialyses on a city bus. The orthopedist says, “It’s about time.”

The new hips are in place, physical therapy does its thing, Mr Green’s wife becomes critically ill, and Clarence, without palpable help, is transferred to a nursing home in Paducah.

I question the government’s prudent judgment in paying for bilateral total hip replacements to save three taxi fares a week and particularly because this elaborate maneuver failed to maintain Clarence’s independence. The fates of his house and garden are unknown to me. But I think Clarence is a real man and that the government cares less about containment than do you, I, and Clarence.

**A. Evan Overstreet, MD  
Editor**



**The AMA  
Hospital Medical Staff Section  
Seventeenth Assembly Meeting  
June 20 - 24, 1991  
Chicago Marriott Hotel  
Chicago, Illinois**

**Highlights of the Annual Meeting will include:**

- an educational program on the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and Practice Parameters;
- presentation by the AMA-HMSS Governing Council of reports on medical staff issues including Evaluation of the Hospital Medical Director and Criteria for Evaluating the Performance of the Hospital Medical Director, PRO Required Education of Hospital Medical Staff and Patient Responsibility of On Call Physicians;
- an information exchange on PRO and Managed Care Review;
- AMA-HMSS Governing Council elections for the positions of Delegate, Alternate Delegate and one Member-At-Large.

**For Information Contact:**

Department of Hospital Medical Staff Services  
American Medical Association  
515 North State Street  
Chicago, Illinois 60610  
Phone (312) 464-4754 or 464-4761



**HMSS**

## Thanks for the Memories!



**T**HANKS to the Kentucky Medical Association for all their support and encouragement during this past Auxiliary year from April '90 to April '91. It has been a pleasure for me to be the liaison between the Auxiliary and the Kentucky Medical Association. We always know and realize that without this great group of physicians there would not be an Auxiliary and that we could not assist and work with these members.

**T**HANKS to all the staff at the Kentucky Medical Association office who have helped me through this year. Special thanks go to Jean Wayne, Sue Tharp, Rick Hahn, Don Brinley, Don Chasteen, and Bob Cox. I appreciate how they all have personally assisted me.

**T**HANKS to our Auxiliary for permitting me to be your president. I hope that each member of the board that worked so diligently on our projects, along with the support of over 1,000 members, had as much pleasure working toward our goals as I have. Without such support from this board, our year could not have been a success.

**T**HANKS to all our Auxilians whose spouses were called to the Gulf Crisis. While their hearts, minds, and love were with their spouses, they still found time to support and work toward our efforts. I hope that through our year of working together, everyone feels that we have "Improved the Image of Medicine."

*Betty Schrodt*

**AKMA President**



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of the pack.**

# QUIT



**American Heart  
Association**

## Camp Hendon at KYSOC A Camp for Children With Diabetes

A week-long camping trip for diabetic children is usually out of the question due to the difficulty in maintaining a healthy blood sugar ratio. Back in 1965, Doctor J. Robert Hendon recognized the problem and organized the first week-long campout in Kentucky for kids with diabetes. In the 25 years since, Camp Hendon, named for its founder, has measurably enriched the lives of its participants.

Located at Camp Kysoc near Carrollton, KY, this diabetes camp offers all the fun activities you expect -- fishing, swimming, canoeing, arts and crafts, and nature hikes, but with a twist! Qualified medical staff including nurses, dieticians, certified diabetes educators and diabetic support staff are on hand to continue proper treatment. At the same time, independence is encouraged and the kids are even taught the mechanics of self-treatment. The children will find it rewarding to share experiences with other kids who have the same problems. This is also a well deserved break for the primary caregivers.

This year's camp will be held July 28 - August 3. For more information call the American Diabetes Association Kentucky Affiliate 9 AM - 4 PM weekdays at 502/589-3837 or write them at 745 W Main St, Louisville, KY 40202. While most of the goods and services are donated, expect to pay a small fee. A limited number of "camperships" are available for those families in need of financial assistance. **Application deadline is May 7, 1991**, but request information as soon as possible because space is limited.

## Sexually Transmitted Disease Reporting

**T**O THE EDITOR: The strengthened regulations on reporting of sexually transmitted diseases, promulgated in November 1989, unfortunately were not reflected in the Special Article *Release of Patient Medical Records* in the January 1991 issue of the *Journal*. The patient's name and address are now required in the reporting of sexually transmitted diseases. In order to counteract the increasing incidence of sexually transmitted diseases, and in view of the reliability of protection of confidentiality by Kentucky public health officials, it is important that physicians provide this full identifying information. Such details are helpful, most importantly in our efforts to limit infectious syphilis spread and eliminate the recent reappearance of congenital syphilis.

The reporting by code, mentioned in the first paragraph of article XIV of the Special Article, now applies only to the reporting of HIV infection. That code could be soundex plus birth date, or initials plus birth date.

**Reginald Finger, MD, MPH**  
**Clarkson T. Palmer, MD, MPH**  
 Division of Epidemiology  
 Kentucky Department for Health Services

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*This letter was referred to the author of the article in question, and his reply follows:*

## Release of Patient Medical Records

**T**O THE EDITOR: Drs Finger and Palmer correctly point out an error in Section XIV of the "Release of Patient Medical Records"

article in the January 1991 issue of the *Journal*. Section XIV, which refers to Kentucky Regulation 902 KAR 2:020, should state that reports of sexually transmitted diseases, *except* HIV, must include the name and address of the patient.

To insure clarification, pertinent portions of 902 KAR 2:020 are set forth verbatim as follows:

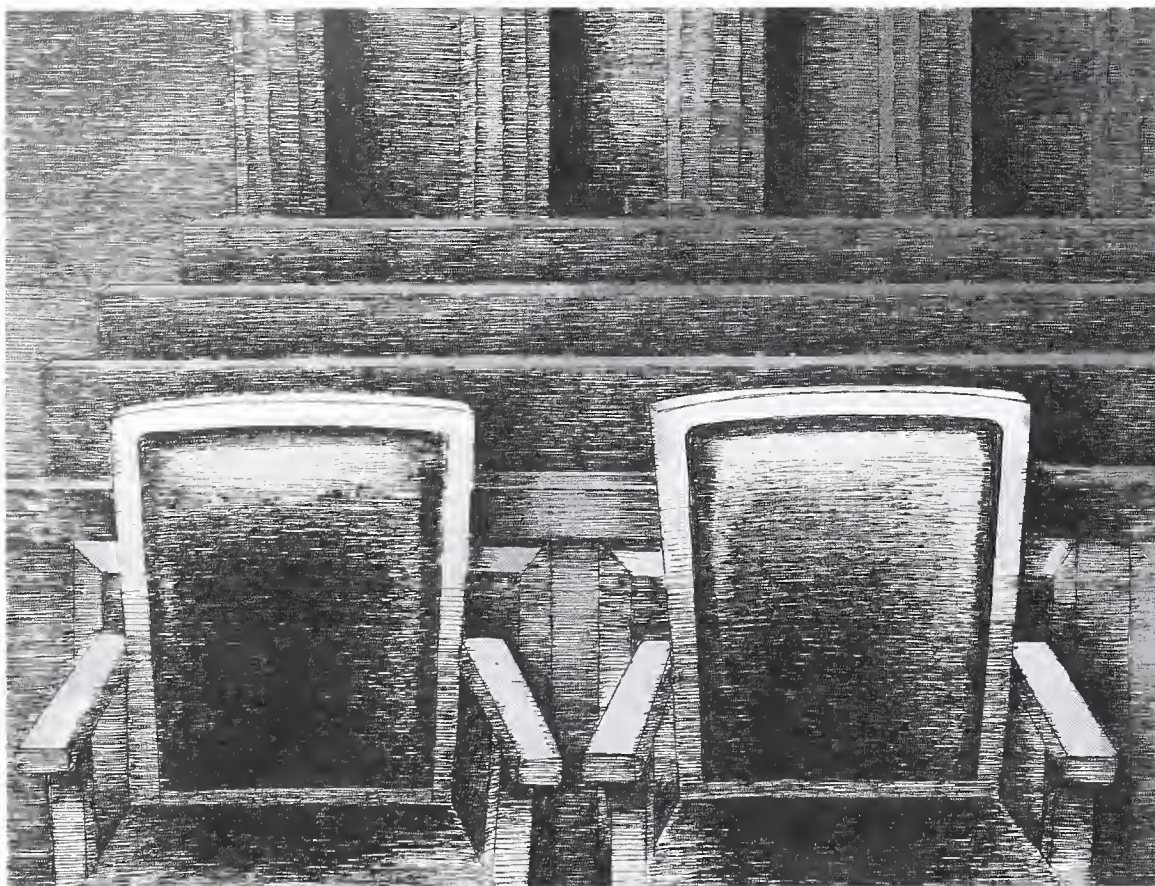
(4) . . . Except for diseases listed in Section 1(3) of this regulation [chicken pox] and human immunodeficiency virus (HIV), all reports shall contain the name and address of the patient as well as pertinent clinical, laboratory, and epidemiological information. Reports of human immunodeficiency virus (HIV) shall be identified by a code (such as soundex plus birth date, or initials plus birth date). The code shall always be the same for a given patient but, in and of itself, shall not identify the patient. All reports shall include birth date, sex, race, and county of residence. Reports of AIDS (acquired immune deficiency syndrome) and human immunodeficiency virus (HIV) infections shall include the following risk factors, if known:

- (a) Homosexual male contact;
- (b) History of intravenous drug use;
- (c) Hemophilia;
- (d) Receipt of blood products;
- (e) Heterosexual contact with paragraphs (a) through (d) of this subsection; and
- (f) Birth to an infected mother.

We appreciate Drs Finger and Palmer bringing this to our attention.

**Charles J. Cronan IV**





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## APRIL

**17-18 — Sixth Annual Geriatric Medicine Seminar**, "Nutrition and Ethical Issues," sponsored by Jewish Hospital, Louisville, KY; Bottigheimer Auditorium, Jewish Hospital, 217 E Chestnut St, Louisville, Ky; \$95 for physicians; \$60 for non-physicians. Contact: Terri Graham, RN, Director of Primary Care/Senior Services, 502/587-4685.

**19-20 — Update Workshop in Diabetes:** Pathogenesis and Treatment of Noninsulin-Dependent Diabetes Mellitus, Hyatt on Capitol Square, Columbus, OH. Contact: Ohio State University, 800/492-4445.

**19-21 — Sports Medicine for Physicians;** Hyatt Regency Hotel, Lexington, KY. Contact: Ms Joy Greene, Director CME, 132 College of Medicine Office Bldg, U of K, Lexington, KY 40503-0086; 606/233-5161.

**25-27 — High Risk Pregnancy Postgraduate Course**, Hyatt Regency Hotel, Louisville, KY. Contact: Laura Tucker, CME, University of Louisville, Louisville, KY 40292; 502/588-5329.

**26-28 — Diagnostic Dilemmas in Cardiology**, Kingston Plantation, Myrtle Beach, SC. Contact: LaDonna Nail, Southern Medical Association, 35 Lakeshore Dr, Birmingham, AL 35219-0088; 1/800/423-4992; 205/945-1840.

**26-27 — Contemporary Pediatrics for the Practicing Physician;** Hyatt Regency Hotel, Lexington, KY. Contact: Ms Joy Greene, Director CME, 132 College of Medicine Office Bldg, U of K, Lexington, KY 40503-0086; 606/233-5161.

**30-May 2 — Molecular Basis of Bone Cell Physiology:** Transcellular Signaling, The Sheraton West Port Inn, St Louis, MO. Contact: Cathy Caruso, Office of CME, Washington University School of Medicine, 660 S Euclid, Box 8063, St Louis, MO 63110; 800/325-9862, 314/362-6893.

## MAY

**3-5 — Diagnostic Dilemmas in Neurology and Psychiatry**, The Grand Hotel, Point Clear, AL. Contact: LaDonna Nail, Southern Medical Association, 35 Lakeshore Dr, Birmingham, AL 35219-0088; 1/800/423-4992; 205/945-1840.

**10-11 — Nineteenth Annual C. Dwight Townes Symposium**, The Seelbach Hotel, Louisville, KY. Norman S. Jaffee, MD, senior American surgeon in the field of lens implantation, will give Townes lecture; William Tasman, MD, ophthalmologist-in-chief at Wills Eye Hospital, will discuss retinal diseases and their treatment; and section on new neurodiagnostic testing presented. Contact: Mrs Rodman, 502/588-5466.

**16-19 — Focus on the Female Patient**, Bay Point Resort, FL. Contact: LaDonna Nail, Southern Medical Association, 35 Lakeshore Dr, Birmingham, AL 35219-0088; 1/800/423-4992; 205/945-1840.

**18 — Nephrology Seminar**, University of Louisville Health Sciences Center Auditorium, Louisville, KY. Contact: Laura Tucker, CME, University of Louisville, Louisville, KY 40292; 502/588-5329.

**19-24 — Twenty-Second Family Medicine Review — Session II;** Hyatt Regency Hotel, Lexington, KY. Contact: Ms Joy Greene, Director CME, 132 College of Medicine Office Bldg, U of K, Lexington, KY 40503-0086; 606/233-5161.

## JUNE

**3-7 — Seventh Annual EVMS Family Medicine Review Course;** The Cavalier Hotels, Virginia Beach, VA. Sponsored by Department of Family and Community Medicine of the Eastern Virginia Medical School. Contact: Eastern Virginia Medical School, PO Box 1980, Norfolk, VA 23501, or call 804/446-6140.

**9-13 — Fifteenth Symposium on Lung Disease**, The Cloister, Sea Island, GA. Contact: LaDonna Nail, Southern Med-

ical Association, 35 Lakeshore Dr, Birmingham, AL 35219-0088; 1/800/423-4992; 205/945-1840.

**12-15 — American Academy of Family Physicians**, Kentucky Chapter, Annual Meeting, Galt House, Louisville, KY. Contact: Gayle Knopp, 502/451-0370.

**13-14 — Cardiology in Practice**, Hyatt Hotel on Capitol Square, Columbus, OH. Contact: Ohio State University, 800/492-4445.

**13-15 — 36th Great Smoky Mountains Pediatric Seminar**, Park Vista Hotel, Gatlinburg, TN. Contact: The University of Tennessee Department of CME, 1924 Alcoa Hwy, D-116, Knoxville, TN 37920; 615/544-9190.

**17-21 — Thirteenth Family Medicine Review**, Hyatt Regency Hotel, Louisville, KY. Contact: Laura Tucker, CME, University of Louisville, Louisville, KY 40292; 502/588-5329.

**21-23 — Focus on the Chronically Ill Patient**, Sandestin Beach Hilton, Destin, FL. Contact: LaDonna Nail, Southern Medical Association, 35 Lakeshore Dr, Birmingham, AL 35219-0088; 1/800/423-4992; 205/945-1840.

## SEPTEMBER

**14 — Lasers and Beyond**, presented by N.D. Radtke, MD, and Humana Hospital Audubon. Category I credit. Contact: N.D. Radtke, MD, 240 Audubon Medical Plaza, Louisville, KY 40217; 502/636-2823.

## OCTOBER

**27-November 1 — Twenty-Second Family Medicine Review — Session III;** Hyatt Regency Hotel, Lexington, KY. Contact: Ms Joy Green, Director CME, 132 College of Medicine Office Bldg, U of K, Lexington, KY 40503-0086; 606/233-5161.



# **Pfizer Pharmaceuticals First Major Manufacturer to Make Products Available to Kentucky Physicians Care**

Thousands of low-income Kentuckians may receive free prescriptions and pharmacy services through a new program, "Kentucky Pharmacy Providers," that was launched in July 1990.

An agreement has been reached with the Kentucky Health Care Access Foundation, the Kentucky Pharmacists Association, and Pfizer/Roerig Pharmaceuticals to make Pfizer Labs' and Roerig's entire line of prescription drug products available to KPC patients *at no charge*. (To be eligible for the KPC program, patients must have incomes at or below the Federal Poverty Income guidelines and cannot be eligible for any government assistance programs such as Medicare and Medicaid.)

Pfizer Labs and Roerig sales representatives are calling on KPC participating physicians to make them aware of the full range of Pfizer/Roerig products available to KPC, and physicians are encouraged to see them when possible.

In extending this access to prescription drugs, Pfizer will make its Pfizer Labs and Roerig brand pharmaceuticals available at no cost, and participating pharmacists will dispense them without charge to eligible ambulatory patients. The estimated combined value of these goods and services exceeds \$1 million. *Only prescriptions written for Pfizer/Roerig products for KPC eligible patients by KPC participating doctors will be filled through the Kentucky Pharmacy Providers Program.*

The Pfizer and Kentucky Pharmacists Association program will help fill a significant void in KMA's effort to help the less fortunate. The Kentucky Health Care Access Foundation and KPC Operating Committee are hopeful that other manufacturers will offer their assistance in the future.

If you have questions, or for those physicians not currently participating in KPC who wish to participate, please contact the KPC referral office — 1/800/633-8100, or the KMA Headquarters Office — 1/502/459-9790.

**PLEASE REFER TO THE FOLLOWING PAGES  
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**Carroll**  
Parklane Pharmacy  
Webster Drugs

**Carter**  
Horton Brather & Brawn  
Rase Pharmacy

**Christian**  
Express Pharmacy  
Harn Prescription Shop  
Jennie Stuart Medical Center  
Save More Drug  
The Medicine Shoppe

**Clark**  
Corner Drug Store  
Day Drugs  
SuperX Drugs

**Clay**  
Family Drug Center  
H & N Drug  
Medi Center Drugs

**Crittenden**  
Glenn's Apatheary

**Cumberland**  
Smith Pharmacy

**Davies**  
Danhauer Drug Company  
Emery Centre Pharmacy  
Greene's Pharmacy  
Horreld's Drug Store  
Mayfair Pharmacy  
Medical Plaza Pharmacy  
Medicine Shoppe  
Nation's Medicines  
Tolayr Drug #21  
Wol-Mort Pharmacy

**Edmonson**  
Prescription Shop

**Fayette**  
Hi-Acres Pharmacy  
Hubbard & Curry Pharmacy  
Hutchinson Drug  
All Kroger Pharmacies  
Professional Arts Apatheary  
Randall's Pharmacy  
Taylor Drugs  
The Medicine Shoppe  
Warehouse Drugs  
Wadhill Pharmacy

**Fleming**  
Plazo Pharmacy

**Floyd**  
Archer Clinic Pharmacy  
Betsy Loyne Pharmacy  
Mud Creek Clinic Pharmacy  
Our Lady Of The Way Hospital

**Franklin**  
East Side Pharmacy  
Fitzgerald Drugs  
Kroger Pharmacy  
Medicine Shoppe  
Tolayr Drugs  
The Prescription Center

**Fulton**  
City Super Drug  
Evans Drug Company  
Rumfelt Drug  
SuperX Drugs

**Garrard**  
Suttan Pharmacy

**Grant**  
Grant County Drugs

**Graves**  
Stones Drugs  
SuperX Drugs  
Wilson Rexall Drugs

**Grayson**  
Clarkson Drug Store

**Green**  
Model Drug Store

**Greenup**  
Scott Drugs  
Stultz Pharmacy

**Hardin**  
Jeff's Prescription Shop  
Kroger Company  
Shawers & Hays Drugs  
SuperX Drugs  
Taylor Drugs

**Harlan**  
Lynch Med. Services Pharmacy  
SuperX Drugs

**Harrison**  
Eastside Pharmacy Of Cynthia  
Lee Drugs

**Hart**  
Branstetter Pharmacy  
Clarks  
Mallory Drugs

**Henderson**  
Dunoway's Imperial Pharmacy  
T & T Drugs

**Henry**  
Cook's Pharmacy

**Hopkins**  
Earlington Pharmacy  
Family Drugs  
Madisonville Pharmacy  
Nation's Medicines  
Professional Drugs #2  
SuperX Drugs

**Jackson**  
Annville Pharmacy  
Clinic Pharmacy

**Jefferson**  
Alliont Health System Pharmacy  
Art Jacob Prescription Shoppe  
Colonial Drugs  
Cox's Pharmacy  
DBA Hometek Pharmacy  
Hording Pharmacy  
Holdaway Drugs  
Hume Pharmacy  
Kaby Drug Company  
All Kroger Pharmacies  
Oak Drug Company, #1  
Rouben's Pharmacy  
St. Denis All Core  
All SuperX Drugs  
All Tolyr Drugs  
Union Prescription Center  
Wal-Mart Pharmacies  
Warehouse Drugs

**Jessamine**  
Drug Mort  
Medicine Shoppe  
Tolayr Drugs

**Johnson**  
Bi-Rite Pharmacy

**Kenton**  
Blank's Pharmacy  
Boeckley Drugs  
Cherokee Drug Shoppe  
Crestville Drugs  
Farrell Pharmacy  
Fort Mitchell Drug Shoppe  
Fort Mitchell Pharmacy  
Ludlow Drugs  
Medical Village Pharmacy  
Morwessel Drugs  
Nie's Independence Pharmacy  
Save Discount Drugs  
All SuperX Drugs

**Knox**  
Knox Professional Pharmacy  
Sav-Rite Pharmacy

**Laurel**  
Family Drugs  
Kelley's Medical Arts Pharmacy  
Laurel Heights Nursing Home  
London City Drug Co.  
London-Corbin Pharmacy  
SuperX Drugs

**Lee**  
Stufflebeon Pharmacy  
Three Forks Apothecary

**Letcher**  
Parkway Pharmacy  
Shopwise Pharmacy

**Lincoln**  
Coleman's Drug Store  
Rishie Drugs

**Livingston**  
Glenn's Prescription Center

**Logan**  
Gower Drug Store  
Riley-White Drugs  
Wal-Mart Pharmacy

# PARTICIPATING PHARMACIES

## KPC PHARMACY PROVIDER PROGRAM

**Madison**  
Berea Hospital Out-Patient  
Kroger Company  
SuperX Drugs

**Magaffin**  
Clinic Pharmacy

**Marian**  
Pat's Pharmacy  
Southall Pharmacy

**Marshall**  
Benton Discount Pharmacy  
Draffenville Pharmacy  
J & R Pharmacy  
Nelson ValuRite Pharmacy  
Pay-N-Save Discount Drugs

**Mason**  
Medical Arts Pharmacy  
Toncray Martar & Pestle

**McCracken**  
Davis Drugs  
Katterjahn Drug Store  
Kroger  
SuperX Drugs  
The Medicine Shoppe

**McCreary**  
Burgess Drug Store  
Daugherty Drugs

**Meade**  
Riverview Pharmacy

**Mercer**  
Kroger Company  
SuperX Drugs

**Metcalfe**  
Metcalfe Drugs  
Nunn Drugs

**Mantgamery**  
Calica & Whitt Drug  
Emil W. Baker, Pharmacist  
Rass Drugs  
SuperX Drugs

**Muhlenberg**  
Beechmant Pharmacy  
Clinic Pharmacy

**Nelson**  
Snider Drugs

**Nicholas**  
Carlisle Drug

**Ohio**  
L. L. Bone Pharmacy  
Rice Drug Store  
Spinks' Pharmacy

**Oldham**  
Taylor Drugs

**Owsley**  
Owsley Prescription Center

**Pendleton**  
Moreland Drug

**Perry**  
L. B. Clinic Pharmacy  
SuperX Drugs  
Vicca Pharmacy

**Pike**  
Medical Pharmacy  
Nichals Apothecary  
SuperX Drugs

**Pulaski**  
Brown's Bogle Street Pharmacy  
Kroger Company  
Samerset Pharmacy  
SuperX Drugs  
The Medicine Shoppe  
Tibbals Drug Store  
Wal-Mart Pharmacy

**Rackcastle**  
Mt. Vernon Drive-Thru  
Yaungs Pharmacy

**Rawan**  
Cave Run Pharmacy

**Russell**  
Daugherty Pharmacy  
Hopper Drug

**Scott**  
Dactor's Park Pharmacy  
Fitch Drug Store  
Kroger Company

**Shelby**  
Smith-McKenney

**Simpson**  
Arnold Drug Company  
Prescription Shop  
R. H. Moore Drug Company  
Shugart & Willis

**Spencer**  
W. T. Froman Drug Company

**Taylor**  
Central Drug Center  
Kroger Company  
SuperX Drugs  
The Medicine Shoppe

**Tadd**  
Weathers Drugs

**Trigg**  
Save On Drugs

**Union**  
Corner Drug Store  
Professional Drugs #1  
Sturgis Pharmacy

**Warren**  
Ashley Circle Pharmacy  
C. D. S. #10 Drug  
Clinic Pharmacy  
Medicine Shoppe  
Northgate Pharmacy  
SuperX Drugs  
Taylor Drugs  
Williams Drug Company

**Washington**  
County Drug

**Wayne**  
Daffron Drug  
F & H Drug  
Plaza Drugs

**Webster**  
Providence Pharmacy  
Thrifty Pharmacy, Inc.

**Whitley**  
Cottangim Drug Company  
Doctors Park Apothecary

**Walfe**  
Campton Discount Drugs

**Woodford**  
Corner Drug of Versailles  
Midway Drug  
SuperX Drugs  
Taylar Drugs



# Prevention:

## Rx for Health Care in the 90s

*KMA Annual Meeting · Sept 29 - Oct 3*

*Hyatt Regency Hotel · Lexington, KY*

**L**EXINGTON . . . the very name conjures images of sleek thoroughbreds galloping through pastures of manicured bluegrass, white-columned mansions shaded by ancient oaks, and mile after mile of white plank fences paralleling quaint country roads.

But, like the times, Lexington is changing, capturing for itself a reputation not only as thoroughbred capital of the world, but also as one of America's thoroughbred cities and, nowadays, a first-class meeting and convention site.

The Hyatt Regency Lexington and the Lexington Center will serve as headquarters for the 1991 KMA Annual Meeting September 29-October 3.

The Hyatt Regency Lexington, located in the heart of Lexington's shopping and entertainment center, offers 635 luxurious guest rooms, a pool, free self-parking, valet parking and service, a multimedia entertainment lounge, and a fine restaurant. The Hyatt is connected to the Lexington Center/Rupp Arena and Civic Center Shops mall offering 36 eclectic shops featuring stylish clothing boutiques and gift galleries and six fabulous relaxing indoor "cafes."

Lexington is a city devotedly cherishing reminders of its rich heritage while vigorously building for tomorrow's challenges. Lexington caters to visitors with the same

gracious Southern charm that continuously greets royalty, sheiks, and international dignitaries.

Those people come to Lexington to savor the unique flavor of life in the Bluegrass, a flavor that features a tantalizing blend of large-city amenities and small-town friendliness. That unique blend is epitomized by Triangle Park, an urban oasis located on the site of Lexington's founding settlement. The park's cascading fountains and flowering pear trees add a special garden flavor to downtown while providing a focal point for community evenings or a quiet evening stroll. Admire the "heart of the city" by riding the trolley, a convenient and inexpensive way to get around the downtown area, or, if you prefer, take an elegant horse-drawn tour of downtown Lexington in a carriage traditionally handcrafted by the Amish.

Friendly people dedicated to the American work ethic, Lexingtonians enjoy a city that offers a special quality of life admired throughout the world. Come join us and be a part of the 1991 KMA Annual Meeting September 29-October 3.

*kma*



*America's Best of Show:*

*Lexington*  
KENTUCKY

# Reasons to Attend the 141st KMA Annual Meeting

## Scientific Sessions

The Hyatt Regency Lexington and Lexington Center will host the 1991 Annual Meeting. The Scientific Program Committee has invited speakers from across the nation to participate in the sessions to be held during the mornings of October 1, 2, and 3.

## Specialty Groups

Programs for 22 specialty groups will be held during the afternoons of October 1, 2, and 3. No general sessions are scheduled during the specialty group meetings and all KMA members are invited. Scientific sessions and specialty group meetings will be held in the Lexington Center. By completing CME sign-up sheets at the beginning of each meeting, physicians attending general sessions and specialty group meetings will qualify for Category 1 Credit.

## KMA House of Delegates

The opening meeting of the House of Delegates will be held Monday, September 30, at 9 AM in the Regency Ballroom located in the Hyatt Regency Hotel. Reference committee meetings will begin at 1:30 PM on Monday and the final meeting of the House will begin at 7 PM Wednesday, October 2. Officers for the 1991-92 Associational year will be elected during the final House meeting.

## Other Activities

The 29th Annual KEMPAC Seminar will be held Monday evening, September 30, in the Patterson Ballroom, located in the Hyatt Regency Hotel. A reception begins at 6 PM with dinner at 7 PM, and the program to follow at 8 PM.

The President's Luncheon will be held October 2 with presentations of KMA awards and the installation of the 1991-92 KMA President, S. Randolph Scheen, MD.

Scientific and Technical Exhibits will be on display featuring new medical products, services, and techniques. Members and guests have an opportunity to visit this area during the 30-minute intermissions scheduled throughout the general sessions and specialty group meetings.

*Why not come to Lexington in September and experience a KMA Annual Meeting for yourself? Afterwards, we are confident you will add to this list many more reasons for attending.*



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## PEOPLE

In 1990, the KMA Auxiliary presented **Rose Gardner** of Louisville with an "Extra Mile" award for outstanding volunteer service.

A past president of the Kentucky Auxiliary, Mrs Gardner has been involved in auxiliary work for more than 30 years. She has served as a board member of the Jefferson County Auxiliary and Legislation Committee chairman and treasurer of the AMA Auxiliary. With her husband, **Hoyt D. Gardner, MD**, who is a past AMA president, she has traveled the nation and the world to promote medical and health issues.

**Angie DeWeese**, wife of KMA past president **Bob M. DeWeese, MD**, and president-elect of the Jefferson County Auxiliary, lavishes praise on Mrs Gardner. "I think the nicest tribute I can give to this elegant lady is to say that her values have not changed with the years. She has spoken to countless young physicians and their spouses over the years, and her advice has stayed the same: 'Be concerned for patients and patient care, support candidates who support quality medicine, and support your local, state, and national associations.'"

Two years ago, Mrs Gardner put all of her energies into a joint project of the Jefferson County Medical Society and auxiliary, organizing hundreds of volunteers to help serve meals, manage a clothes closet, and develop several service projects at the John H. Morgan Center for homeless men (see April 1990 *Journal of KMA*). She is co-administrator of the center, and serves on the county medical society Foundation and Outreach Boards, as well as on the county auxiliary's board.

**Hirikati S. Nagaraj, MD**, has been elected president of the Kosair Children's Hospital Medical Staff.

**Stephen P. Wright, MD**, is the president-elect and **Toni M. Ganzel, MD**, is secretary-treasurer. Members at-large are: **Salvatore J. Bertolone, MD**, **Anthony J. Casale, MD**, **John Norton, MD**, **Walter E. Badenhause, Jr, MD**, **Sue Ann Cutliff, MD**, and **Harold L. Harrison, MD**. **Ronald Lehocky, MD**, is the past-president.

**Henry D. Garretson, MD, PhD**, has been elected president of the Norton Hospital Medical Staff. **Jesse H. Wright, MD, PhD**, is the president-elect and **Marjorie R. Fitzgerald, MD**, is the new secretary-treasurer. Members-at-large are **Robert W. Linker, III, MD**, and **Thomas M. Woodcock, MD**. **Maynard L. Stetten, MD**, is the past president.

The University of Kentucky College of Medicine has announced the following appointments of physicians to its faculty: **Yosh Maruyama**, Acting Chairman, Radiation Medicine; **Abner Golden**, Clinical Professor, Pathology; **David L. Cowen**, Professor and Chairman, Rehabilitation Medicine, and Interim Chairman, Medicine; and **Wayne C. Myers**, Professor, Pediatrics. Dr Myers has also been named Director, Center of Excellence for Rural Health, College of Medicine.

The University of Louisville reports that **Thom J. Zimmerman, MD**, has been appointed to the Ophthalmology Advisory Panel of the United States Pharmacopeial Convention, Inc. USP is a nonprofit organization that sets legal standards for drugs in the US.

Dr Zimmerman will provide input on clinical aspects of USP's work in relation to drug standards and information. He also will assist in determining content of the USP DI data base. USP DI is widely used by the medical and pharmaceutical communities to determine the medical acceptability of unlabeled uses of medications, defining drug utilization review parameters, and

determining what patients should know about medications to help ensure safe and effective use.

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## UPDATES

### U of L receives eye research grant

Research to Prevent Blindness has awarded the School of Medicine a \$50,000 grant for advanced research into the prevention and treatment of sight-threatening diseases.

The monies will be administered by **Thom J. Zimmerman, MD**, chairman of the Department of Ophthalmology and Visual Sciences.

The unrestricted grant provides maximum scientific freedom to explore new avenues in achieving a better understanding of the eye and its diseases.

Research to Prevent Blindness awards grants to medical schools and is the world's leading voluntary organization in support of eye research. Previous grants and awards to U of L total \$506,800.

### Medical equipment donated for US troops

Approximately \$2 million worth of equipment to set broken bones was donated by the University of Louisville School of Medicine for the US troops in the Persian Gulf.

Nearly 1,000 Hoffmann External Fixateurs were sent to Bahrain. Fixateurs are slender bars with pins at either end that hold the broken bone together, said **Dr Stephen Henry** of U of L. The devices can be fitted in 3 to 4 minutes, unlike a cast, which can take hours to set.

The fixateurs were donated to U of L by Kentucky Medical Research and Development Inc of Louisville. The university had been using them for research.

---

**NEW MEMBERS**

*Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.*

**Daviess**

**Barbara E. Carr, MD** — R  
1100 Walnut St, Owensboro 42301  
1980, Ohio State

**Philip B. Hurley, MD** — ORS  
2816 Veach Rd, Owensboro 42301  
1981, U of Arkansas

**Felicity W. Polio, MD** — FP  
1800 Lexington Ave, Owensboro 42301  
1987, U of Cincinnati

**Fayette**

**Deborah E. Powell, MD** — PTH  
3345 Overbrook Dr, Lexington 40503  
1965, Tufts U

**Gayle A. Roberts, MD** — IM  
1720 Nicholasville Rd #103,  
Lexington 40503  
1966, U of Louisville

**Franklin**

**Wanda C. Gonsalves, MD** — FP  
3376 Lyon Dr, Lexington 40513  
1984, U of Kentucky

**Jefferson**

**George E. Quill, Jr, MD** — ORS  
4130 Dutchmans Ln, Louisville 40207  
1984, Northwestern U

**Wayne M. Shugoll, MD** — C  
4010 Waterford Cir #8, Louisville 40207  
1982, U of Maryland

**Pike**

**Rao S. Bhatraju, MD** — S  
804 Cline St, Pikeville 41501  
1971, Guntur Medical College, India

**Pulaski**

**Bob Winston, MD** — P  
349 Bogle St, Somerset 42501  
1981, George Washington U

**Warren**

**Douglas B. Thomson, MD** — IM  
201 Park St, Bowling Green 42101  
1979, U of North Carolina

**New In-Training****Jefferson**

**Edward L. Brewer, MD** — AN  
**Walter R. Butler, MD** — P  
**Randall G. Drye, MD** — NS  
**Arthur G. Duncan, MD** — AN  
**Paul L. Fleming, MD** — EM  
**Marc A. Marcum, MD** — S  
**John C. Matteucci, MD** — S  
**Eileen R. Perry, MD** — AN  
**Maria A. Schiaffino, MD** — FP  
**John H. Storey, MD** — S  
**David A. Thomas, MD** — AN  
**Michael H. V. Tran, MD** — R  
**Stephanie P. Walton, MD** — IM  
**Dennis W. Wulfeck, MD** — R

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**DEATHS**

**Mortimer H. Moseley, MD**  
Eddyville  
1921-1991

Mortimer H. Moseley, MD, a family practitioner, died January 3, 1991. A 1944 graduate of Indiana University School of Medicine, Dr Moseley was an active member of KMA.

**Ansel V. Simon, MD**  
Middletown  
1912-1991

Ansel V. Simon, MD, a retired family practitioner, died February 5, 1991. Dr Simon was a 1940 graduate of the University of Louisville School of Medicine and a life member of KMA.

**Harry Goldberg, MD**  
Louisville  
1896-1991

Harry Goldberg, MD, a retired orthopedic surgeon, died February 18, 1991. A 1920 graduate of the

University of Louisville School of Medicine, Dr Goldberg was a life member of KMA.

**Charles G. Bryant, MD**  
Louisville  
1913-1991

Charles G. Bryant, MD, a retired family practitioner, died February 22, 1991. Dr Bryant was a 1937 graduate of the University of Louisville School of Medicine. He was a past president of the Kentucky Academy of Family Physicians which also honored him as Citizen-Doctor of the Year in 1967. Dr Bryant was past president of the Jefferson County Medical Association, a former Alternate Delegate to the American Medical Association, and a life member of KMA.

**Lewis Fine, MD**  
Louisville  
1910-1991

Lewis Fine, MD, a retired dermatologist, died February 28, 1991. Dr Fine was a 1935 graduate of the University of Louisville School of Medicine and a life member of KMA.

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# KEMPAC Elects Officers for 1991

KEMPAC officers elected for 1991 are as follows:

David B. Stevens, MD	Chairman
William P. VonderHaar, MD	Treasurer
Henry R. Bell, Jr, MD	Assistant Treasurer
Jerry Martin, MD	Secretary

The members of the KEMPAC Board of Directors are your representatives and encourage you to discuss political activity in your local area with them.

The districts and directors are:

## First Congressional District

Henry R. Bell, MD — PO Box 517, Elkton, KY 42220

Larry Franks, MD — 216 Berger Road, Paducah, KY 42001

## Second Congressional District

Salem George, MD — 1129 W Chandler, Lebanon, KY 40033

Jerry Martin, MD — 1167 31 W By-pass, Bowling Green, KY 42101

## Third Congressional District

Wayne W. Kotcamp, MD — Ste 200, 601 S Floyd St, Louisville, KY 40202

William P. VonderHaar, MD — 1170 E Broadway, Ste 400, Louisville, KY 40204

## Fourth Congressional District

Harry W. Carter, MD — St. Elizabeth Medical Ctr, Covington, KY 41014

Ronald L. Levine, MD — 250 E Liberty, Ste 510, Louisville, KY 40202

## Fifth Congressional District

James D. Crase, MD — 340 Bogle St, Somerset, KY 42501

William D. Pratt, MD — Medical Arts Bldg, London, KY 40741

## Sixth Congressional District

G. Irene Minor, MD — PO Box 4010, Berea, KY 40403

David B. Stevens, MD — 1900 Richmond Road, Lexington, KY 40502

## Seventh Congressional District

Samuel J. King, MD — PO Box 3207, Pikeville, KY 41501

Kenneth R. Hauswald, MD — PO Box 1865, Ashland, KY 41101

## Represent Auxiliary to KMA

Mrs Donald R. Neel (Faye) — 3 Stone Creek Park, Owensboro, KY 42303

Mrs Maurice J. Mueller (Kathy) — 78 Superior Avenue, Ft Mitchell, KY 41017

Mrs George Schafer (Pat) — 732 Greenridge Lane, Louisville, KY 40207

Mrs Thomas Slabaugh (Sugar) — 2160 Island Drive, Lexington, KY 40502

## Exofficio Members

Donald C. Barton, MD — Doctors' Park, Corbin, KY 40701

Wally O. Montgomery, MD — PO Box 7329, Paducah, KY 42001

Sam D. Weakley, MD — 220 Baptist East Office Park Bldg, Louisville, KY 40207

\_\_\_\_\_ YES, I wish to become a KEMPAC/AMPAC member.

\_\_\_\_\_ \$100 Physician      \_\_\_\_\_ \$100 Spouse      \_\_\_\_\_ \$10 Resident      \_\_\_\_\_ \$10 Student

Personal check enclosed \_\_\_\_\_      Charge to my credit card      \_\_\_\_\_ VISA      \_\_\_\_\_ Master Card

Credit Card No. \_\_\_\_\_

Expiration Date \_\_\_\_\_

Signature \_\_\_\_\_

If your practice is incorporated, KEMPAC and AMPAC voluntary political contributions should be written on a PERSONAL CHECK. Contributions are not limited to the suggested amount. Neither the AMA nor the KMA will favor or disadvantage anyone based upon the amounts of or failure to make PAC contributions.

A portion of voluntary political contributions will be used in connection with Federal elections and are subject to the prohibitions and limitations of the Federal Election Campaign Act. Contributions are not tax deductible.

# APPLICATION FOR SCIENTIFIC EXHIBITS

Kentucky Medical Association  
1991 Annual Meeting

Lexington Center, Lexington, KY  
October 1-3

1. Title of exhibit \_\_\_\_\_
2. Name(s) of exhibitor(s) \_\_\_\_\_  
Address \_\_\_\_\_  
Professional title \_\_\_\_\_
3. Institution if other than exhibitor \_\_\_\_\_
4. Amount of backwall footage required \_\_\_\_\_  
(The draped booth has 4' side walls. This footage should not be included in backwall footage required). TABLE DESIRED? \_\_\_\_\_  
(Table 2' deep x width of backwall (footage) ELECTRICAL OUTLET DESIRED? \_\_\_\_\_
5. Will summary printed matter be available or obtainable for the interested physician? \_\_\_\_\_
6. Indicate sources of assistance provided to you in connection with this exhibit \_\_\_\_\_
7. Has this exhibit been displayed before? If so, when & where? \_\_\_\_\_  
\_\_\_\_\_
8. It is required that you attach a rough sketch or photograph and a brief outline of your exhibit to include: (a) content of the presentation and (b) the method, eg, equipment to be used.

Date \_\_\_\_\_

Signature of Applicant

Fill Out and mail to:  
RICHARD A. KIELAR, MD, Chairman  
Scientific Exhibits Committee  
Kentucky Medical Association  
3532 Ephraim McDowell Drive  
Louisville, Kentucky 40205

The Kentucky Medical Association welcomes and supports scientific exhibits as a facet of continuing postgraduate education.

Applications for space should be received before June 1, 1991.

- **COMMERCIALISM**, such as utilizing the name of sponsoring organization or facility, either on the exhibit or in printed materials, is **PROHIBITED**.
- KMA provides, without cost to the exhibitor, one 2 ft. table, bracket lights and a title sign.
- Spotlights, view boxes, furniture, decorations, etc, may be furnished by the exhibitor or may be rented, if desired, by applying directly to the George E. Fern Company, 3752 Crittenden Dr, Louisville, Kentucky 40209.
- Transportation and erection costs are the responsibility of the exhibitor.
- Exhibit must be attended during intermissions to answer physicians' questions. It is also desirable to have someone in attendance throughout the program.
- Equipment which will create noise must not be used during the general sessions and, at other times, must be controlled by head or earphones or a muffling device.
- Exhibit must be dismantled and removed by 4:00 PM, Thursday, October 3, 1991.
- Exhibit space is strictly limited to footage and space allotted. No exhibit may extend into the aisle.

Lexington Center and the Kentucky Medical Association or its agents cannot guarantee against loss or damage and will assume no liability for damages nor guarantee the exhibitor against loss of any kind. The exhibitor agrees, with the Association, to be responsible to the Lexington Center for damages that may occur as a result of the exhibitor's use of the facility.



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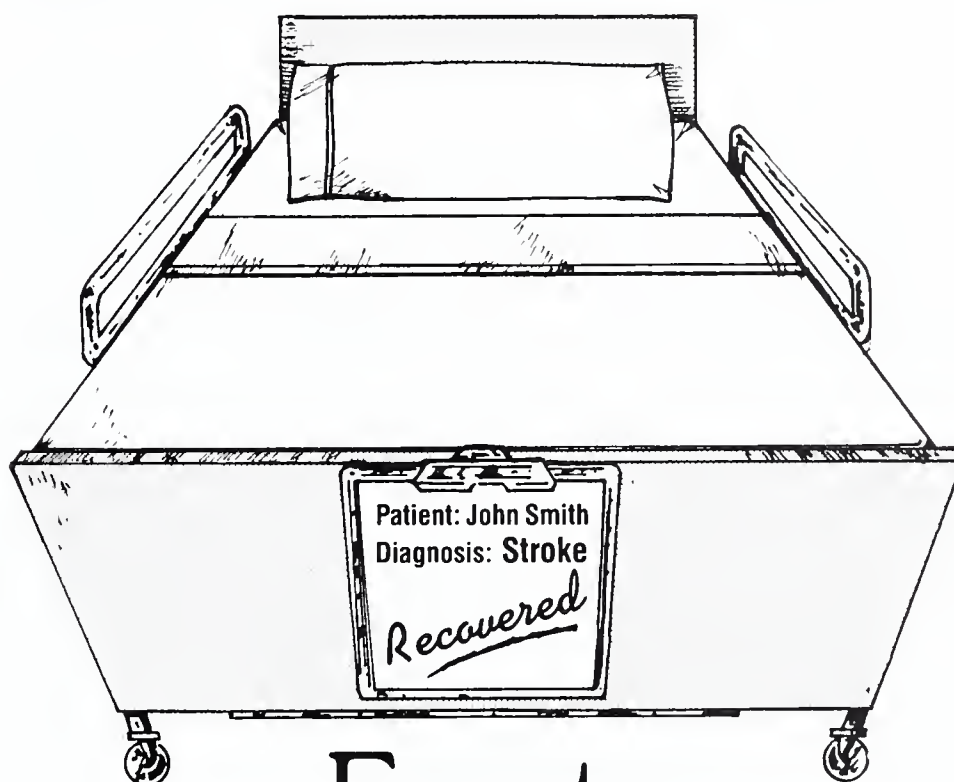
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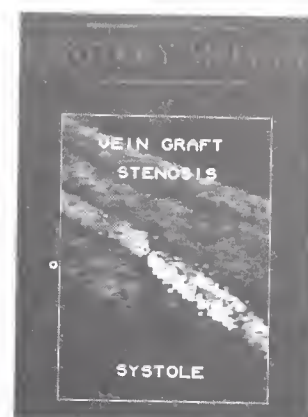
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## We Need A Few Good Physicians

**A**merica's infrastructure totters and appears headed toward meltdown. Banking, savings and loan, insurance, health delivery, legal, prison, transportation, workers' comp, environmental, and others too numerous to mention, face bankruptcy or collapse. An over-politicized electoral system based on nothing more than "getting re-elected or winning," hamstring meaningful restructure and reform.

Maybe our forefathers never intended for government to work. The system in itself is an anathema with all the various checks and balances that insure a snail's pace and the unlikelihood that anything important can happen. Government consists of legislative, administrative, and judicial branches, two legislative bodies, numerous court systems with multiple appellate levels, and two major political parties. This is compounded by the fact that the system operates on four levels including city, county, state, and federal. Some even propose adding an international system based on the United Nations which would add to the jungle of government. Into this intricate maze, a troubled Kentucky General Assembly convenes in January 1992, faced with a newly elected Governor and administration. Issues including taxes, environmental measures, education, health care costs, Medicaid, workers' compensation, and a myriad of other problems rest squarely upon the shoulders of the 138 members of the Kentucky General Assembly.

Other issues aside, the health delivery system could well become the

"whipping boy" of the 1992 Session. One legislator, under attack from his union and small business constituency over health costs, grouched, "I'm ready to do something about the health delivery system even if it's wrong." He wasn't totally serious, but we recognize his frustration in trying to maintain equilibrium between those who seek to dismantle the entire system and start over versus those of us who recognize the uniqueness and quality embodied in the present system. Be aware that there are destructive elements out there with overriding economic interests who could care less about quality and believe cost should be the overriding factor in health care decisions.

KMA has enjoyed a luxury in the past two or three Sessions of being positive — working on safety and health measures and various other joint projects with our allies. But that may change in 1992 if the anticipated assault begins. Based on contacts with legislators and aides, you may see the following legislation introduced:

- Mandatory participation in Medicaid/Medicare.
- Hospital/hospital based physician rate/fee review commission.
- Mandatory CME.
- Legislation defining physicians' offices and services that can be performed in those offices.
- Health Data Commission requiring extensive reporting on services, fees, individual procedures, etc.
- Triplicate prescription requirement.
- Mandatory testing for AIDS, including health providers.




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***“Support and contribute to political candidates who share your . . . philosophical beliefs. Join KEMPAC. KEMPAC serves as Kentucky medicine's political arm. The current 15% to 20% of physicians, KEMPAC members, and spouses can no longer carry the entire load.”***

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**“... WE NEED A FEW GOOD PHYSICIANS. We are asking for more volunteers to serve as legislative key contacts. . . . If you are willing to become involved and if the issues which I have innumrated are important, drop me a note giving your name, office and home phone numbers, along with names of legislators you will work with.”**

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- Mandatory physician's office medical waste pickup.
- Patient access and ownership of medical records.
- Direct insurance billing by physician extenders.
- Prescriptive privileges for nurse practitioners.

Other frustrations include coping with drastic alterations in the Kentucky General Assembly committee structure, especially the Health and Welfare Committees.

In the past, two physicians (Jack Trevey/Nick Kafoglis) have been seated on the six-person Senate Health and Welfare Committee, providing medicine a luxury few states enjoyed. In 1992, the seven-person Health and Welfare Committee will have “zero” physician representation. Adding to our stress level, four legislators extremely supportive of medicine who served on the 1990 House Health and Welfare Committee lost their seats. Other changes in committee structures also create challenges to KMA's legislative effort. To make a long story short, **WE NEED A FEW GOOD PHYSICIANS.** We are asking for more volunteers to serve as legislative key contacts. Volunteer key contacts will advise legislators by informing them of medicine's position and make themselves available before, during, and following the 1992 Session. If you are willing to become involved and if

the issues which I have innumrated are important, drop me a note giving your name, office and home phone numbers, along with names of legislators you will work with. There is an old saying that, “The second bite by a junkyard dog is absolutely not an educational experience.” We have been bitten on occasion on both the federal and state level and let me assure you that now is not the time for us to back off and be ambivalent toward the legislative process.

In closing, individual effort is crucial to our political/legislative program. Support and contribute to political candidates who share your economic, political, and philosophical beliefs. Secondly, join KEMPAC. KEMPAC serves as Kentucky medicine's political arm. The current 15-20% of physicians, KEMPAC members, and spouses can no longer carry the entire load. They need your help and, in fairness, you need to share in this process. We started out the year talking about **PRIDE IN MEDICINE** and being positive about what we do, what we mean to our communities, and securing our profession for the coming generation. As so often stated, freedom demands vigilance. The maintenance of our profession and our very survival requires that same vigilance and intensity.

**Preston P. Nunnelley, MD**  
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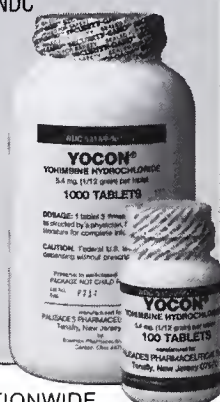
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1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
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# Insulin Adjustment by the Sliding Scale Method— A Straw Man Who Won't Stay Down?

Duncan R. MacMillan, MD

*The sliding scale method of insulin adjustment is seldom effective in establishing diabetic control because there is no anticipation of upcoming insulin needs and dosage changes are after-the-fact reactions to existing blood sugar levels.*

Professionals involved in diabetes education prefer to imagine that diabetics everywhere are optimally treated with the most scientific and physiological methods. However, a recent encounter with a medical insurance interrogator confirmed what most diabetologists secretly fear—the “Sliding Scale” is not dead. In defending my admission of a ketotic out-of-control young diabetic, I was queried “What is your treatment plan? Sliding scale? That’s what most doctors use.”

The news came as no great shock but served as a reminder that facile medical formulas that are easy to write tend to endure regardless of whether or not they make physiologic sense.

Objections to the sliding scale method of insulin adjustment have been expressed by diabetologists for years, but have not been published in authoritative references. In an attempt to rectify that situation, I retrospectively reviewed the sliding scale experience existing prior to my arrival at Kosair Children’s Hospital in 1965 and compared it with results obtained subsequently using the method I preferred. This appeared in the *Journal* in September 1970 under the title “The Fallacy of Insulin Adjustment by the Sliding Scale.”<sup>1</sup> My recent third party encounter reminded me that after 20 years this reference was no longer at the fingertips of most practitioners in the state of Kentucky. The reported study did have some limitations, perhaps in some ways comparing apples to oranges, but the criticisms of the sliding scale were validated. It is amusing that the original manuscript was rejected by a leading national journal in September 1968 with the following re-

viewer comments: “I think that the paper does a service in showing that regular insulin, when administered on a sliding scale basis only, is a very poor and inadequate therapy. However, it seems that the author is somewhat in the situation of creating a straw man in order to knock him down . . . the criticisms the author makes . . . are valid but have led most centers to disregard the sliding scale system completely.” Twenty-two years later the straw man is showing amazing resiliency, if we are to believe our third party authority.

A convincing denouncement of the sliding scale method has recently appeared in *Practical Diabetology*,<sup>2</sup> authored by Bernard Shagan, Professor of Medicine at Hahnemann University School of Medicine. This article entitled “Does Anyone Here Know How to Make Insulin Work Backwards?” outlines the physiological irrationality of the sliding scale, and the associated editorial comments are equally condemnatory.

The sliding scale method, as such, no longer appears in any major textbook or reference source, but some intensive insulin therapy regimens are oriented toward current glycemic status to an alarming degree. To avoid propagation of the sliding scale, no attempt will be made to describe it in detail or to cite specific references. It is a method of insulin dose determination based exclusively on the current glycemic (or glycosuric) status with no attempt made to anticipate the upcoming needs or to refer back to the effects of the doses given at the same time on previous days. Generally, it is used with QID regular insulin programs but the “sliding scale mentality” extends to BID programs of regular and modified insulin. In many versions, the dose prescribed for higher levels of hyperglycemia or glycosuria is excessive, at least for children, and there is often a total “bailout” for normoglycemia or aglycosuria with no insulin being given.

The sliding scale may be justified in patients receiving all intake via the intravenous route where

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## Insulin Adjustment

each 6 hr period is similar to the last. However, dosage modifications still have to be made in a rational manner avoiding the tendency in most sliding scale programs to give too much for hyperglycemia and too little or none for normoglycemia. A supplementary regular insulin sliding scale for current hyperglycemia is used effectively by some diabetologists, but only superimposed on a more forward-focused or anticipatory primary method of insulin adjustment.<sup>3,4</sup> Even in this context, playing catch-up with insulin doses can distort the glycemic patterns on which the primary adjustment is based and the overall impact on glycemic equilibrium is adverse.

My personal objections to insulin adjustment by a sliding scale are as follows and are taken verbatim from a teaching slide constructed 25 years ago:

1. The sliding scales are designed to correct the inadequacies of the previous 6 hr period rather than anticipating the needs of the ensuing 6 hr period, ie, insulin administration is out of phase with requirements.

*Current comment: Constantly playing catch-up is no way to establish glycemic equilibrium and control.*

2. Control is almost impossible to establish if insulin is omitted when aglycosuria is achieved.

*Current comment: The same applies for updated sliding scales which dictate an insulin dose of 0 units if normoglycemia is approached or attained. Some insulin is generally required to avoid marked hyperglycemia by the time of the next scheduled dose.*

3. Nocturnal hypoglycemia frequently occurs because largest dose is usually given at bedtime to correct post-supper hyperglycemia.

*Current comment: It makes sense to give the bigger insulin dose before supper in anticipation of the meal. Large doses at bedtime should be avoided.*

4. The sliding scale can lead to a pattern of alternating large doses and small doses.

*Current comment: It is very easy to get into a ping pong pattern of insulin administration in which an excessive insulin dose (or even an appropriate dose) produces a blood sugar response which dictates a subsequent low dose (or no dose) which in turn results in marked hyperglycemia and a repetition of the excessive dose and so on.*

A carefully controlled prospective study comparing regular insulin administered according to a sliding scale with a program of regular insulin administration in a more physiologic and anticipatory fashion would be welcomed and hopefully would discourage continued use of the sliding scale. However, since this method has been discarded at most academic centers where such a study would most logically be conducted, it seems unlikely that such a study will be done. Theoretical arguments along with anecdotal and retrospective evidence should still suffice to discourage use of the sliding scale as a primary method of achieving diabetes control.

It is hoped that there will not be a recurring need to repeat this message in another 20 years. However, I suspect if the need no longer exists it will be because revolutionary new methods of diabetes treatment or a cure have been developed, rather than because an irrational method of management will have spontaneously disappeared from the diabetes care armamentarium. In any case, the straw man will at last be laid to rest.

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# Acute Mycotic Aneurysm of the Ascending Aorta Following Aortocoronary Bypass: Successful Repair

Ronald M. Barbie, MD; Roland E. Girardet, MD;  
Allan M. Lansing, MD, PhD; John C. Norman, MD

*Acute mycotic aneurysms of the ascending aorta following aortocoronary bypass are exceedingly rare. To our knowledge, there have been few reports of successful management. The central location of this lesion places it apart from acute or chronic mycotic aneurysms in general and enhances its lethality. The availability of ascending and arch aortography, computerized chest tomography and the techniques of peripheral cardiopulmonary bypass, deep hypothermia and reversible circulatory arrest for prolonged periods of time permit successful management. The purpose of this report is to (1) illustrate such a problem; (2) describe its successful management; (3) review the etiology of mycotic aneurysms, historically and contemporarily; and (4) to differentiate early, acute mycotic aneurysms of the ascending aorta following aortocoronary bypass (usually lethal) from similar late chronic processes (readily reparable).*

## Case History

A 63-year-old woman with a history of three vessel coronary artery disease, hypertension, and diabetes mellitus was admitted to another institution because of severe chest pain. Myocardial infarction was ruled out with serial isoenzymes and electrocardiograms. During this admission she experienced an episode of ventricular tachycardia which necessitated electrocardioversion. She was converted to normal sinus rhythm and was treated with a lidocaine infusion. There were no further episodes of ventricular tachycardia but there were occasional premature ventricular contractions. Cardiac catheterization

demonstrated a 90% obstruction of the left anterior descending coronary artery, a 95% obstruction of the circumflex coronary artery, and a 60% obstruction of the right coronary artery with normal left ventricular function. The patient was transferred to our institution for coronary bypass surgery.

Her past medical history included coronary artery occlusive disease, hypertension, type II diabetes mellitus, osteoarthritis, and status post hysterectomy and unilateral oophorectomy. Her medications included Vasotec 10 mg po each day, Lozol 2.5 mg po BID, Potassium Chloride 750 mg po TID, DiaBeta 5 mg po each day, Dipyridamole 25 mg po TID, and Allopurinol 300 mg po each day.

On physical examination a grade II/VI systolic ejection murmur was heard across the precordium with radiation to the neck. Otherwise there were no remarkable findings. The electrocardiogram showed a normal sinus rhythm with a ventricular rate of 85, right bundle branch block, left anterior fascicular block, and occasional premature ventricular contractions. No Q-waves or ST changes were noted. The admission chest film was unremarkable.

The patient underwent quadruple coronary artery bypass with reverse saphenous vein grafts to the left anterior descending, right, posterior marginal and lateral marginal branches of the circumflex (the latter two in sequential fashion) employing cold blood cardioplegia with a terminal warm infusion, topical hypothermia, and insertion of temporary ventricular pacing wires. The total bypass time was 100 minutes, the aortic-cross clamp (ischemic) time was 71 minutes, the flow rate was 60 ml/kg/min, the blood loss was

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## Acute Mycotic Aneurysm of the Ascending Aorta



**Fig 1 — Ascending aortography showing a 23 millimeter acute, expanding pseudoaneurysm extending off the left ascending aortic root, probably originating from a proximal aortosaphenous vein proximal anastomosis.**

300 ml, and the patient received two units of packed cells during the procedure.

Her postoperative course was uncomplicated except for the development of atrial fibrillation which was converted to a sinus mechanism with the addition of Procan SR therapy. She was discharged 9 days later.

Two weeks later she was readmitted to another institution complaining of nasal congestion, cough, fever, chills, nausea, vomiting, myalgias and arthralgias of approximately 5 days duration. Her temperature was 101.5 and the physical examination was unremarkable except for slight erythema of the pharynx and nasal turbinates. The white blood count was 17,500 with 90 polymorphonuclear leukocytes, 8 lymphocytes, and 2 monocytes. A chest film showed slight increased density in the left costophrenic angle, and was otherwise unremarkable. A second chest film 2 days later showed bilateral pleural fluid collections and a patchy area of consolidation in the

posterior aspect of the left lower lobe. Two blood cultures were positive for *Staphylococcus aureus*. The white count was 16,900 with 94% segmented polymorphonuclear leukocytes, 4 lymphocytes, and 1 monocyte consistent with a shift to the left. She was started on antibiotics, initially Unasyn which was changed to Keflin. The admission hemoglobin was 10.1 with a hematocrit of 30.4. The following day it was 9.4, with a hematocrit of 28.3, decreasing to 8 and 24.4 and subsequently to 7.6 and 22.8. The chest film showed a left lower lobe infiltrate and probable effusion. There were patchy infiltrates at the right base and the mediastinum was wider than on admission.

The patient was transferred to our institution. The white count was 29,700, the temperature was 100.9, the respiratory rate was 44, and the blood pressure was 170/111. She was receiving Ancef 2 grams q6h, Lopressor 50 milligrams po BID, Vasotec 5 milligrams po BID, and Zantac 50 milligrams IV q8h. Her hemoglobin was 8.6, the hematocrit 26.9, and the platelet count was 657,000. She complained of burning anterior chest pain, shortness of breath, and was anxious. The chest film showed a markedly enlarged cardiac silhouette. Ascending aortography revealed a 23 millimeter pseudoaneurysm extending off the anterior left lateral aspect of the aortic root (Fig 1). A CT scan of the chest showed a 4 centimeter abnormality in the suprasternal notch, highly suspicious for a focal abscess, and a larger 10 centimeter abnormal lesion in the anterior mediastinum (Fig 2). Bilateral pleural effusions were noted. The physical examination then revealed a 6 × 3 centimeter fluctuant collection in the upper portion of the previously healed midline sternotomy. Aspiration of this revealed moderate white cells, occasional red cells, and rare gram positive cocci. The patient was intubated for controlled ventilation.

At operation, right femoral vein to right femoral artery bypass was established and the patient was cooled to 16°F. The patient was then exsanguinated into the heart/lung machine and cardiopulmonary bypass was stopped. In this manner, with deep hypothermia and circulatory arrest, the sternum was opened and a fluctuant mass larger than the heart was encountered. The ascending aorta and heart were markedly displaced, posteriorly. After removal of the hematoma, active bleeding was seen to come from a proximal saphenous vein graft anastomosis. Another saphenous vein graft in the immediate proximity was not involved. The first vein graft had dehiscd

from the aorta. It was ligated distally and the proximal anastomosis site, probably the origin of the pseudoaneurysm, was oversewn with pledgeted 2-0 Prolene and 3-0 Prolene sutures. After two episodes of circulatory arrest lasting 40 and 12 minutes each, rewarming was initiated via the right femoral vein-femoral artery bypass and at 28°F the heart was defibrillated. All areas of the mediastinum were copiously irrigated with Bacitracin and Neomycin solution. Intravenous Kefzol was given two times during the procedure and the sternum was closed over two mediastinal tubes for drainage. A total of 1750 ml of blood and blood products were used. The patient made an uneventful recovery and was discharged 1 month later.

## Discussion

**Definition:** The term "mycotic" aneurysm was introduced by Osler in 1885 to define those aneurysms that resulted from septic emboli originating from bacterial endocarditis.<sup>1</sup> In these situations, infection reaches the vessel by direct embolic occlusion of the lumen or via the vasa vasorum (blood supply) to the arterial wall. Infected aneurysms, however, can develop by other methods, and currently the term "mycotic aneurysm" is commonly used in a broader sense than originally intended. Such pseudoaneurysms can result from injury to the arterial wall with concomitant or subsequent infection of the hematoma. Localized sepsis can also spread to involve adjacent vascular structures with necrosis of the arterial wall, followed by limited bleeding and hematoma formation. Liquefaction of the central portion of the hematoma forms a pseudoaneurysm that is secondary to the infection, per se. Since the problems of management are similar for all types of infected aneurysms, the term "mycotic aneurysm" has come to include all infected aneurysms, both true and false, that result from a variety of causes, including embolization, trauma, or localized sepsis.<sup>2</sup>

**Mechanisms:** The development of these aneurysms is most commonly described in three categories.<sup>3,4</sup> The first mechanism, which has been reported to account for 80% of mycotic aneurysms, involves septic embolization within the arterial lumen from bacterial endocarditis. There follows a gradual weakening with enlargement of the artery and aneurysm formation. Aside from embolic phenomena, septicemia may result in lodgment of bacteria in the vasa vasorum or on



**Fig 2 — Computerized axial tomography scan of the chest showing a 4 centimeter abnormality in the suprasternal notch and a larger 10 centimeter abnormal lesion in the anterior mediastinum.**

atherosclerotic lesions of the intima with subsequent formation of a true aneurysm. A second mechanism involves infection of an already formed, usually atherosclerotic, aneurysm with ultimate destruction of a portion of the arterial wall, which results in hemorrhage, perhaps temporarily confined by hematoma formation. This usually occurs during a course of septicemia from either a known or unknown source. A third mechanism is from contiguous spread, either directly or via lymphatics, from a localized abscess or area of cellulitis, which destroys the arterial wall causing massive bleeding or the formation of a pseudoaneurysm.

Recently, a fourth mechanism has emerged and involves injury to an artery associated with concomitant contamination and the subsequent formation of an infected pseudoaneurysm as described by Fromm and Lucas<sup>5</sup> and Huebl and Read.<sup>6</sup> This most frequently occurs from external trauma or during vascular operations. This entity represents a poorly contained infectious process with more diffuse inflammation of the surrounding soft tissues as compared with the discrete true



## Acute Mycotic Aneurysm of the Ascending Aorta

mycotic aneurysm in which the infection is confined to the arterial wall. Mycotic aneurysms of the ascending aorta originating at one or more of the proximal aorto-saphenous vein anastomotic sites emerge as a subset within this fourth area. They may form as a result of disruption of the anastomosis with hematoma formation and subsequent infection, or from primary sternal-anterior mediastinal infection with contiguous spread to the anastomosis. Our analysis suggests that mycotic aneurysms of the ascending aorta following aortocoronary bypass in this fourth category can be further divided into two groups — early acute in the immediate postoperative period (frequently lethal) and late chronic, ie, months to years following operation (probably reparable).

*Current and Related Cases:* We believe that the successful management of the current case hinged on three important factors: (1) a high index of suspicion in view of an infectious process, following aortocoronary bypassing in association with a decreasing hemoglobin and hematocrit; (2) the use of advanced imaging and angiographic techniques (ascending aortography and computerized axial tomography) to confirm or refute these suspicions, and (3) the immediate availability of peripheral cardiopulmonary bypass via the femoral vein and artery, deep hypothermia and reversible circulatory arrest after achieving core temperatures in the 17-20 range, hemodilution to hematocrits in the region of 20%, and a minimal period of circulatory arrest (45-60 minutes) with the use of steroids and barbiturates for cerebral protection.<sup>7</sup>

The lethality of such lesions is emphasized by the experience of others. Douglas and coworkers<sup>8</sup> reported an instance of infected saphenous vein coronary artery bypass graft with mycotic aneurysm and fatal dehiscence of the proximal anastomosis. Hughes et al<sup>9</sup> reported five patients who developed mycotic aneurysms of proximal aortocoronary vein graft anastomoses attributed to contaminated cardioplegic solution (*Enterobacter cloacae*) infused at the original operation. One developed acute tamponade on the 9th postoperative day, had direct suture of one graft and reanastomosis of a second graft and expired 55 days later. A second developed acute tamponade and expired suddenly on the 9th postoperative day, a third developed acute tamponade on the 11th postoperative day and expired in the operating room despite attempts to institute cardiopulmonary bypass and interpose a fresh seg-

ment of saphenous vein. A fourth patient developed acute tamponade on the 9th postoperative day, was placed on cardiopulmonary bypass, the aortotomy oversewn and a new segment of saphenous vein interposed between the aorta and the original graft. At the time of reporting, this patient was alive and well, free of angina, 3 years after the event.

*Perspectives:* Lillehei and associates<sup>10</sup> first performed successful repair of a mycotic ascending aortic aneurysm using circulatory arrest. Crosby and Tegtmeier<sup>11</sup> subsequently described a patient in whom a large mycotic false aneurysm developed months following aortocoronary bypass grafting. Circulatory arrest was used to gain digital control of the aortic defect, and distal control was obtained after resumption of cardiopulmonary bypass. Debridement of the aneurysm wall, primary repair without prosthetic patching, and antibiotic irrigation were utilized. Crepps and colleagues<sup>12</sup> recently described 10 patients having repair of complex aortic lesions using deep hypothermia and circulatory arrest, including 1 patient with a ruptured mycotic aneurysm of the arch who had not undergone a previous sternotomy. Bailey and coworkers,<sup>13</sup> in a somewhat different setting, reported successful corrective surgery in a child with isolated partial anomalous pulmonary venous drainage who developed an aneurysm within a normal segment of ascending aorta. Bojar et al<sup>14</sup> have recently reported successful repairs of chronic postoperative ascending aortic mycotic aneurysms with circulatory arrest 14, 10, and 10 months postoperatively. And finally, Chan, Crawford and colleagues<sup>15</sup> reported successful repair of two chronic ascending aortic mycotic aneurysms among a group of 22 patients with such processes located throughout the ascending, transverse, descending thoracic and abdominal aorta.

*Summary:* Mycotic aneurysms have been described for more than a century. Their management has improved with the advent of improved methods of vascular surgery and broad-spectrum antibiotics. The advent of aortocoronary bypass surgery, however, has produced a special circumstance wherein sepsis in the vicinity of the ascending aorta with multiple aortotomies and proximal reversed saphenous vein grafts, although rare, is usually lethal. We have reviewed the experience of others and described the successful management of such an acute problem with contemporary techniques. The early acute

process appears far more life threatening than the chronic. The former should be considered in any acute, early infectious process following aorto-coronary bypass procedures.

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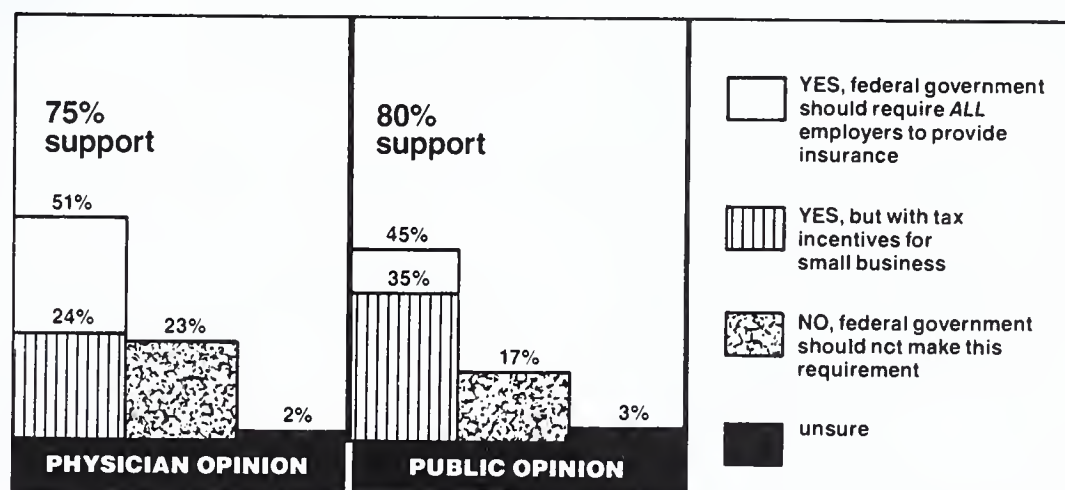
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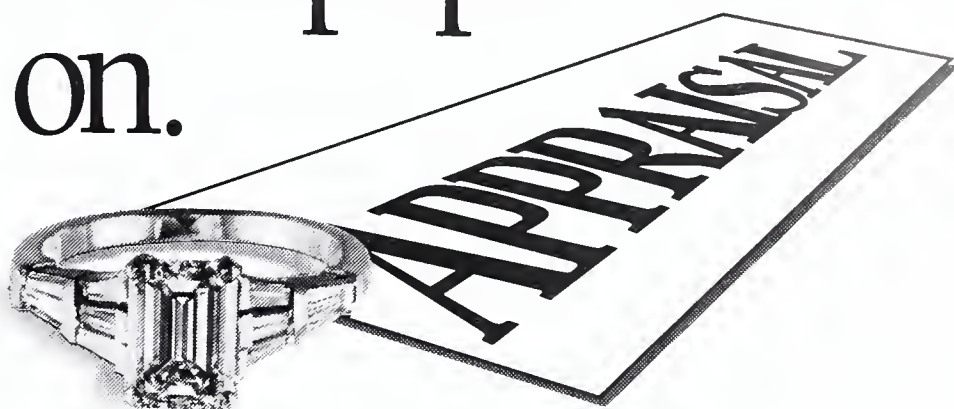
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# Indications and Uses of the Noninvasive Vascular Laboratory: Extremity or Visceral Arterial Evaluation

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*The tests in the noninvasive vascular laboratory are highly accurate for assessing the patient with extremity or visceral artery disease. Once the location and severity of any arterial disease in patients with claudication or critical limb ischemia (ie, gangrene, ulceration, rest pain) is determined by the noninvasive tests, a treatment plan can be developed and then discussed with the patient, with consent obtained prior to any invasive procedure. The presence of hypertension from renal artery stenosis, or chronic mesenteric ischemia from visceral artery stenosis, can be evaluated by duplex scanning, without the need for invasive contrast angiography. Monitoring the function of revascularization procedures, such as angioplasty or bypass grafts, is also possible and significantly improves long-term patency and organ or limb salvage by identifying the need for elective revision of failing reconstructions prior to thrombosis. Noninvasive vascular laboratory tests are the initial procedures of choice for the evaluation of patients with extremity or visceral arterial disease.*

## Introduction

The noninvasive vascular laboratory assessment of a patient with limb or visceral ischemia permits quantitation of the severity of the disease and localization of the diseased arterial segment(s). It also permits the physician to determine the best method of treatment and obtain consent for treatment prior to any invasive procedure. The risks of invasive contrast arteriography are limited to patients who would benefit from revascularization as determined by the physiologic and anatomic results of the noninvasive tests.<sup>1</sup> Those who could be successfully treated with balloon or laser angioplasty can be selected,

permitting proper preparation for these procedures at the time of diagnosis. Risks, costs, and days of hospitalization for the patient thus decrease.<sup>2</sup> The early success and long-term patency of vascular procedures in patients can be significantly improved with the intraoperative and postoperative monitoring of functional patency with noninvasive vascular laboratory tests.<sup>3-5</sup> The key-stone to proper utilization of the noninvasive vascular laboratory is the clear understanding by the referring physician of the indications and clinical usefulness of these procedures. The methodology and indications for using noninvasive vascular laboratory procedures for the evaluation of aortic or visceral arterial disease, lower extremity arterial disease, and intraoperative or postoperative surveillance of vascular reconstructions are discussed.

## Indications and Uses

The noninvasive vascular laboratory examination enhances clinical assessment by quantitating the hemodynamic severity of extremity or visceral arterial disease.<sup>6</sup> It accurately detects any pathology and its physiologic effect, which is relevant to the disease process and its subsequent treatment. These procedures can be classified into two types: direct and indirect (Table 1). The direct tests locate and quantitate the severity of disease at a specific site along a vessel. The indirect tests use physiologic indices at designated levels of the vascular tree as the means of identifying the functional severity of the vascular disease located proximal or distal to the site of measurement.

## Doppler-Derived Pressure Measurements

Doppler-derived pressure measurements are in-

indicated in patients with claudication or critical limb ischemia (ie, gangrene, ulceration, rest pain). Pressure measurements are particularly helpful in diagnosing the cause of an ulcer or foot pain in those patients with multiple possible etiologies, such as neuropathy, vasculitis, infection, or venous disease.

A normal ankle-brachial index is equal to or greater than 1.0. An ankle-brachial index of less than 1.0 is predictive of arterial occlusive disease. Patients with claudication have an ankle-brachial index of  $0.59 \pm 0.15$ ; those with rest pain have an index of  $0.26 \pm 0.13$ ; and those with gangrene have an index of  $0.05 \pm 0.08$ .<sup>7</sup>

### Segmental Pressure Measurements

Segmental pressure measurements can locate and quantitate the physiologic significance of the arterial stenosis or occlusion. In patients with multilevel disease, segmental pressures can identify the level of disease that is causing the most significant physiologic defect. Determination of the presence and level of disease is made by comparing the systolic pressure at each level of measurement. In evaluating segmental pressures of the same extremity, a systolic pressure gradient of greater than 30 mm Hg between cuffs directly correlates with an arterial occlusion in the intervening arterial segment. A profunda-popliteal collateral index of 0.18 or less indicates adequate collateral blood flow through the profunda-popliteal system.<sup>8</sup> For serial examinations of patients with disease, a change of less than 0.15 is within the variability of the test.<sup>9</sup> Segmental limb pressures reliably localizes diseased arterial segments and correlates with the severity of clinical ischemia. However, segmental limb pressures are invalid in patients with incompressible, calcified arteries.

### Segmental Limb and Stress Testing

Segmental limb pressures and stress testing are indicated for patients with pain in the extremity induced by ambulation. Patients with true claudication will have an abnormal stress test and segmental pressures. In normal subjects, the ankle pressure may increase after exercise, may stay the same, or may decrease less than 20% but return to normal within 3 minutes. In patients with vascular occlusive disease, the ankle pressure will drop immediately after exercise and have a prolonged recovery time. The more severe the dis-

**Table 1.** Noninvasive Vascular Laboratory Tests for Extremity or Visceral Arterial Evaluation

Type	Methodology	Indications
Direct	Duplex ultrasonography or color arteriography	Rest pain Gangrene Ulceration Surveillance bypass or angioplasty site
Indirect	Doppler segmental pressures Segmental air plethysmography Photoplethysmography	Claudication Mesenteric ischemia Uncontrollable hypertension

ease, the greater the decrease in pressure and the longer the recovery time. The test simulates the activities that produce symptoms and gives objective data of ankle pressure changes due to occlusive disease. It is reproducible and relatively simple to perform.

**Methodology.** Doppler-derived pressures are measured with the patient in a supine position. The head of the Doppler probe is coupled to the skin with acoustic gel. The continuous wave Doppler is most commonly used, positioned over the artery at a 60-degree angle to the skin. There are two electric crystals mounted at the end of the probe; one emits ultrasonic waves and the other receives the reflected ultrasonic waves. With a pneumatic cuff placed proximal to the Doppler probe, the systolic pressure at the level of the cuff is measured. Segmental pressures of the extremities are measured by placing the cuff at four different locations: high-thigh, above-knee, below-knee, and above the ankle. An ankle-brachial index is calculated by dividing the ankle pressure by the brachial pressure. The profunda-popliteal collateral index, a predictor of the hemodynamic significance of the geniculate collaterals around the knee, is calculated by subtracting the below-knee from the above-knee systolic pressures and dividing by the above-knee pressures.

The severity of arterial disease in patients with claudication can be quantitated by stress testing. The test induces a decrease in the peripheral vascular resistance of the extremity with exercise, thus increasing the blood flow to the extremity. The increase in blood flow to an extremity containing a stenosis will cause an in-



## Noninvasive Vascular Laboratory

crease in resistance at the site of the lesion. This will produce a further decrease in the systolic blood pressure compared with the resting pressure. To perform this procedure, one must first take baseline ankle and arm pressure measurements. The patient then is asked to walk on a treadmill for 5 minutes, or until he is unable to walk further. Ankle and arm pressures are obtained immediately and are repeated until the pressures return to baseline. In those cases in which the patient is unable to ambulate, reactive hyperemia can be induced by inflating a thigh cuff above the systolic pressure for 3 to 5 minutes. Measurements of ankle pressures are then repeated until the pressure returns to baseline.

#### Pulse-Volume Recorder and Photoplethysmograph Digital Pressures

Pulse-volume recorder and photoplethysmograph digital pressures are necessary for those patients with calcified, incompressible vessels because segmental pressures will not be reliable. The diagnostic capabilities of the pulse-volume recorder are based on the contour and amplitude of the pulse waveform of each segment of the extremity. The normal waveform has a quick rise to the systolic peak and a prominent dicrotic notch. Abnormal waveforms have prolongation of the upslope and downslope, with a decrease in the amplitude. The pulse waves are abnormal at the cuff site distal to the location of the occlusive disease in the extremity. Patients with aortoiliac occlusive disease will have abnormal pulse waves in the thigh, calf, and ankle. Patients with superficial femoral artery disease will have a normal thigh cuff waveform but abnormal calf and ankle waveforms.<sup>10</sup>

Digital pressures of the toes are normally lower than those of the brachial artery.<sup>1</sup> Toe pressures that are less than 60% of the ankle pressure indicate significant arterial occlusive disease. Ankle-brachial indexes and toe pressures can predict the likelihood of healing without arterial revascularization and determine the need for vascular reconstruction.<sup>9</sup> Nondiabetic patients with an ankle-brachial index greater than 0.4 or a toe pressure greater than 30 mm Hg will usually be able to heal foot ulcers. The same is true for diabetic patients with a toe pressure greater than 50 mm Hg. Toe pressures less than 30 mm Hg are highly predictive of unsuccessful healing of an ulcer or toe amputation for diabetics and nondiabetics.

**Methodology.** The pulse-volume recorder, a quantitative segmental air plethysmography with high sensitivity and standardization, is commonly used in many laboratories. The pulse-volume recorder test is performed with the patient supine and with standard blood pressure cuffs placed at the thigh, calf, and ankle. Each cuff is individually inflated to 65 mm Hg. The increase in pressure in the cuff, which is due to volume changes in the extremity with each cardiac cycle, is recorded as a hard copy tracing of the pulse wave, similar to the arterial pressure waves.

The photoplethysmograph is a photosensor that measures the content of blood in the skin in direct contact with the probe. The probe consists of an infrared light-emitting diode and a photosensor. The infrared light is attenuated by the content of blood in the skin, which changes with each pulse cycle. The photoplethysmograph can be used to measure digital pressures of the toes and fingers. The probe is applied to the plantar surface of the distal phalanx of the toe with tape that has adhesive on both sides. A pneumatic cuff is placed around the proximal phalanx of the digit and is inflated above systolic pressure, and then deflated until the systolic pressure is equal to the level at which the pulsatile waveform returns.

#### Duplex or Color Scanning

**Extremity Arterial Disease** — Duplex or color scanning is a recently used method for evaluating patients with extremity arterial disease and for studying the anatomy of the iliac, femoral, popliteal, and tibial arteries. Duplex scanning of the extremity arteries is indicated in those patients with claudication or critical limb ischemia who may be candidates for an endovascular procedure. Duplex scanning can locate the diseased arterial segments, permitting planning for treatment prior to arteriography. If stenotic or occlusive arterial lesions are present, the hemodynamic significance of the stenosis can be quantitated. Interpretation of the Doppler flow analysis of the iliac, femoral, popliteal, and tibial vessels is dependent on the change in flow velocity, waveform configuration, and degree of spectral broadening in the stenotic segment, compared with the artery just proximal to the stenosis (Table 2). Percutaneous transluminal angioplasty or laser-assisted balloon angioplasty can be successful if the claudication is a result of a short segmental stenosis or occlusion of the iliac or femoral artery. Treatment plans for the patient

can be made based on the results of the duplex scan, giving the patient and physician time for proper consent, preparation, and performance of these invasive procedures. Doppler pressure measurements and duplex scanning are also indicated in the follow-up of percutaneous transluminal angioplasty of the iliac, femoral, or popliteal arteries. The same criteria for stenosis (Table 2) are also applicable to the evaluation of arterial dilatation sites.

**Methodology.** Duplex or color scanning of extremity arteries is performed with the patient in the supine position, with the legs apart and slightly externally rotated. The aorta, visceral, iliac, femoral, popliteal, and tibial arteries are able to be examined. The transmitting frequency of the duplex scanner is 3 to 5 MHz for the aorta, visceral vessels, and iliac arteries. It is 5 to 10 MHz for the femoral, popliteal, and tibial arteries. The popliteal artery is best examined with the patient in the prone position. Acoustic gels are used to couple the duplex scanner head to the skin. The artery is located and profiled along the longitudinal axis, with the B-mode ultrasound in real time. The Doppler sample volume is placed in the center of the flow stream of the vessel and adjusted to a 60-degree angle. The velocity profile is analyzed by adjusting the range or the sample volume transversely across the artery from far to the near wall. The diameter of the artery is calculated in the sagittal section. The examination proceeds with visualization and Doppler waveform analysis of each of the vessels of interest.

The common and external iliac arteries are best studied after an overnight fast to decrease the amount of bowel gas. With the patient supine, the iliac arteries are located by tracing the aorta down or by locating the femoral arteries in the groin and proceeding upward. The common femoral, profunda femoris, superficial femoral, and tibial arteries are best examined with the patient supine. Longitudinal views permit B-mode imaging and Doppler waveform analysis of the entire length of these arteries, which can reliably identify sites of stenoses. The popliteal arteries are examined with the patient in the prone position, with the legs slightly elevated on pillows.

**Visceral Arterial Disease** — Duplex or color scanning is also indicated in the evaluation of patients with visceral arterial disease, including renal hypertension, intestinal angina, and abdominal aortic aneurysmal disease. The superior mesenteric artery, celiac artery, and renal arteries can be

**Table 2.** Duplex Scan Criteria for Stenosis of the Iliac, Femoral, Popliteal, and Tibial Arteries

Classification by Diameter of Vessel	Criteria
Less than 20%	No increase in peak systolic velocity compared with the adjacent proximal artery; spectral broadening only during systole
20% to 49%	Greater than 30% increase in peak systolic velocity compared with the adjacent proximal artery; spectral broadening during systole and diastole
50% to 74%	Greater than 100% increase in peak systolic velocity compared with the adjacent proximal artery; end diastolic velocity less than 100 cm per second
75% to 99%	Greater than 100% increase in peak systolic velocity compared with the adjacent artery; end diastolic velocity greater than 100 cm per second

identified, and the severity of stenosis in them quantitated. Doppler flow analysis of the aorta and renal artery normally have equivalent peak systolic velocities. A renal-to-aorta peak systolic velocity ratio between 1 and 3.5 is consistent with a 0% to 59% stenosis. A ratio of greater than 3.5 indicates a 50% to 99% stenosis of the renal artery.<sup>11</sup> The renal, hepatic, splenic, and celiac artery waveforms normally have a high diastolic flow rate. The superior mesenteric artery exhibits a reversal of flow in diastole with fasting but has an increase in diastolic flow velocities following a meal.<sup>12</sup> Abdominal aortic aneurysms can also be identified and followed for increase in size by ultrasonic duplex scanning. B-mode ultrasound of the aorta allows measurement of the size of the aorta, accurate evaluation and localization of aortic aneurysms, and the extent of intraluminal thrombus.

**Methodology.** Duplex scanning of the aorta and visceral vessels should be performed in the morning after an overnight fast. The quality of the information received from the examination is best with the smallest amount of intestinal gas present. The test is most easily performed on thin patients. The aorta in the subdiaphragmatic region is imaged first along its longitudinal axis. The celiac and superior mesenteric arteries can also be imaged longitudinally. In the sagittal section the celiac axis, hepatic artery, and splenic artery can be visualized and velocity waveforms recorded. The renal arteries are best imaged transversely, branching off the aorta. The superior mesenteric artery and renal veins are good landmarks for



## Noninvasive Vascular Laboratory

locating the renal arteries. The kidney can be visualized by turning the patient on his side, and velocity waveforms can be obtained from the parenchymal vessels. Adequate examination of the visceral vessels is unobtainable in 10% to 15% of the patients due to intra-abdominal gas, surgical scars, or obesity, even by the most experienced examiners.<sup>11</sup>

**Case Report**

An 81-year-old diabetic man with severe chronic obstructive pulmonary disease and stable angina presented with a nonhealing wound, following the amputation of his fifth toe for an infected ulcer that was located on the plantar aspect of his left foot. The patient had a peripheral neuropathy, strong femoral pulses, but no distal pulses were palpable. The patient's ankle-brachial index (greater than 1.0) was falsely elevated due to calcification of the tibial vessels. Toe pressure of his left leg was 25 mm Hg, consistent with severe limb ischemia. A duplex or color scan of the extremity arteries demonstrated a short 75% to 99% diameter-reducing stenosis of the middle superficial femoral artery, no significant stenosis of the popliteal artery, and a single tibial vessel (peroneal artery) as the run-off to the foot. The patient gave consent for angioplasty of the left superficial femoral artery stenotic lesion at the time of arteriography, which was performed without complications. As a result of this intervention, toe pressure increased to 70 mm Hg after angioplasty. The patient's wound successfully healed after a skin graft.

**Intraoperative Vascular Testing**

Intraoperative vascular laboratory tests are used for hemodynamic evaluation of extremity or vis-

ceral arterial bypass and as a predictor of success of the revascularization procedure. Early failure of autogenous grafts is most commonly due to technical errors. Pulsed Doppler spectral analysis can be used intraoperatively to assess the technical and hemodynamic adequacy of the vein bypass graft. A normal flow velocity waveform is highly predictive of early graft patency. For the *in situ* saphenous vein bypass, peak systolic velocity should be greater than 45 cm per second.<sup>5</sup> Intimal defects, retained valve leaflets, intraluminal thrombus, and anastomotic technical errors can be detected by increases in peak systolic frequency and spectral broadening at the site, as compared with the proximal graft. Fistulas of the saphenous vein *in situ* conduit can be identified by high diastolic flow proximal to the fistula and return to normal waveform distal to the fistula in the graft conduit.

**Methodology.** Pulsed Doppler spectral analysis can be used intraoperatively to detect blood flow disturbances of arterial reconstructions, indicative of technical errors.<sup>3, 5</sup> The entire saphenous vein (*in situ* or reversed), the anastomotic sites, and the flow characteristics of the distal artery can be assessed by placing the gas-sterilized Doppler probe, coupled with saline, directly on the surface of the conduit. The sample volume should be taken in the midstream of the vessel, with the probe held at 60 degrees to the longitudinal axis of the artery. Prosthetic conduits cannot be examined intraoperatively because the material does not permit penetration of the ultrasound beam. The anastomotic sites in the arteries, however, can be studied for blood flow abnormalities.

**Postoperative Noninvasive Vascular Testing**

Postoperative noninvasive vascular laboratory tests of extremity or visceral arterial reconstructions can detect correctable stenotic lesions of the graft prior to thrombosis (Fig 1).<sup>3, 5, 13</sup> Long-term patency of autogenous grafts is significantly affected by the development of graft stenosis due to fibrointimal hyperplasia. The incidence of the development of stenotic lesions that threaten bypass patency ranges from 20% to 26%.<sup>3, 4, 14</sup> The failure to detect and correct the lesions prior to graft thrombosis decreases the long-term patency from over 80% at 5 years to a range of 22% to 47% at 3 years.<sup>3, 15</sup> Duplex scanning and Doppler pressure measurements should be used for assessing the continued effectiveness of bypass grafts. The detection of a failing but still patent bypass graft

**Table 3.** Clinical and Hemodynamic Criteria of a Failing But Still Patent Vein Graft\*

1. Recurrence of symptoms (claudication, ulcer, rest pain, gangrene)
2. Low peak systolic velocity (less than 45 cm per second) of the vein bypass detected by duplex scanning
3. Decrease of peak systolic velocity greater than 30 cm per second and ankle-brachial index greater than 0.15 during postoperative surveillance†

\* *In situ* and reversed bypasses.

† Because of a 20% incidence of graft stenosis that predisposes to bypass thrombosis, surveillance of the vein grafts with duplex scan velocities and ankle-brachial indices are recommended every 3 months for the first 2 years and every 6 months thereafter.



**Fig 1 — Color duplex ultrasonogram of a 75% to 99% stenosis of an in situ saphenous vein bypass. The higher velocities created by the high-grade stenosis are color-coded in blue, green, and white.**

(Table 3) on serial examinations is indicative of the development of a significant stenosis that affects bypass patency and warrants elective revision to maintain viability of the limb.

Duplex scanning can also be performed to monitor dilatation sites after angioplasty. Patency and recurrent stenosis of the dilated arterial site can be detected and monitored for progression. Patients with significant recurrent stenosis will often not have a recurrence of symptoms. The development of a greater than 50% diameter-reducing stenosis of the dilatation site is highly predictive of clinical failure of the angioplasty.

**Methodology.** Postoperative graft surveillance of venous and prosthetic arterial conduits by duplex ultrasonography should be performed at 3-month intervals to detect graft flow abnormalities prior to the development of graft thrombosis.<sup>3, 5, 13</sup> Duplex scanning of the entire venous conduit should be performed prior to discharge to also establish a baseline graft flow velocity. Graft flow velocities of the distal segment of the bypass graft should also be measured at 3-month

intervals after operation.

Duplex scanning of angioplasty sites is performed by locating the artery in a longitudinal profile in real time. The dilated arterial segment is localized from landmarks obtained by angiography. Velocity spectra should be analyzed proximal, distal, and at the site of arterial dilatation.

### Case Report

A 71-year-old hypertensive man underwent a right femoral-peroneal *in situ* saphenous vein bypass for gangrene of the foot. The patient had normal intraoperative and postoperative graft studies. Eighteen months after operation, the patient was noted to have a low flow velocity in the graft (30 cm per second) and a drop in the ankle-brachial index of greater than 0.2 as compared with the last examination. Duplex scanning of the iliac and femoral arteries, the right *in situ* saphenous vein bypass, and the peroneal artery was performed. A 50% to 75% stenosis of the right external iliac artery was detected. The bypass and peroneal artery had no significant stenosis. The cause of the



## Noninvasive Vascular Laboratory

low flow velocity and drop in the ankle-brachial index was a severe iliac artery stenosis due to progression of atherosclerotic disease. The patient subsequently underwent arteriography and angioplasty of the right external iliac artery at the same time without complication. After angioplasty, the graft flow velocity and ankle-brachial index were in the normal range. Duplex scan of the site of the iliac artery angioplasty revealed a less than 15% residual reduction in diameter, indicative of long-term success. Detection of the progression of atherosclerotic disease of the iliac artery with these noninvasive tests permitted elective angioplasty, maintained patency of the failing graft, and thereby saved the patient's limb.

## Summary

The noninvasive vascular laboratory tests are highly accurate in diagnosing extremity arterial disease. They establish the need for vascular procedures based on physiologic data and permit determination of the best method of treatment prior to any invasive procedures. The initial noninvasive vascular test for patients with claudication or critical limb ischemia should be segmental pressure measurements. If the vessels are calcified, pulse volume recording or toe pressures should be obtained. If the limb pressure is normal, other causes of the symptoms should be sought. If the pressures are abnormal, correlation of the patient's symptoms with the severity of disease determines the need for treatment. Duplex scanning of the lower extremity can accurately locate segments of arterial occlusion and quantitate areas of stenoses. If short segmental stenosis is the cause, plans for balloon or laser angioplasty can be made. If long stenotic or occluded segments are present, major vascular reconstruction will be necessary. The early and late success of the angioplasty and bypass procedures should be monitored with serial ankle-brachial indexes and velocities of the conduit to maintain long-term graft patency and limb salvage.

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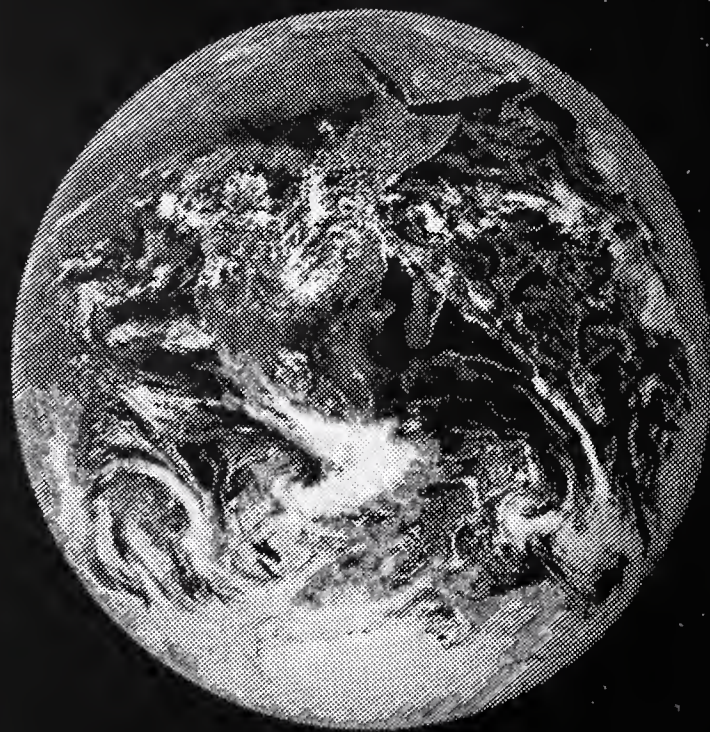
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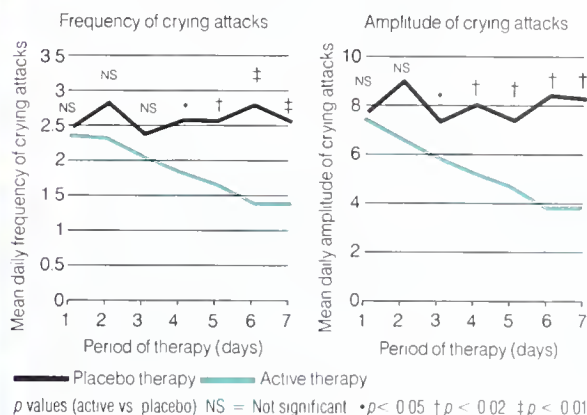
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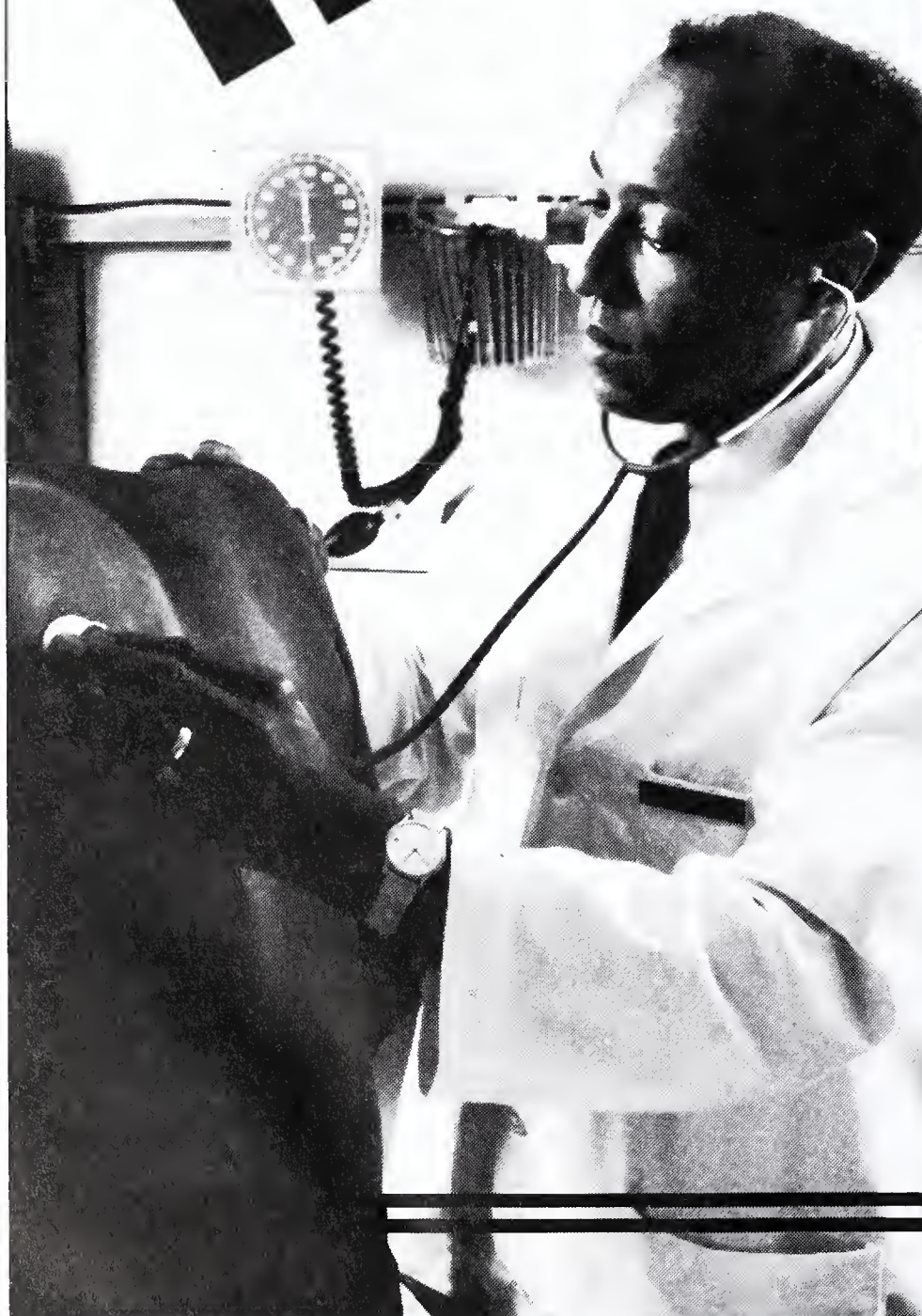
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# Be A Hammer — Not A Nail

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***“We must strengthen our ability to define goals, negotiate, and pull together. . .”***

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It's a frustrating time to be in medicine. I need not reiterate the long and familiar list of sources bludgeoning physicians today, but I'd rather be a hammer than a nail. Just complaining will not get problems solved or effect needed change.

The following are some suggestions which may increase successes in dealing with the forces which influence our professional environments.

- A. First, set goals and objectives. Define as narrowly as possible when, where, and what needs to be accomplished and formulate a plan or proposal.
- B. Be prepared and be specific. Spend some time fact-finding. When possible, get firsthand experience with the situation. See it yourself or experience the problem yourself. Then be specific with your opportunity for improvement. If there are books or articles supporting your position, cite them or copy them to strengthen your request or proposal.
- C. Good negotiating is the real key to success whether you are dealing with patients, employees, the

hospital administration, third party payors, or regulation agencies.

1. Aim for long-term solutions and an ongoing positive relationship. Many times extreme force, ie, screaming and threatening, will produce short-term results at the expense of an ongoing mutually beneficial relationship — you win the battle and lose the war.
2. Establish trust. Most physicians are altruistic individuals (or they wouldn't be in medicine) who are interested in the welfare of the patient, the hospital, the community, and the world. Self interest rarely engenders support for your cause. Emphasize the benefit others will receive from your proposal.
3. Set up a win/win situation to avoid energy consuming power struggles. Almost every situation can be negotiated so that both parties come out ahead. For example, if my department gets this piece of equipment, the hospital will make more money. If the insurance company reimburses for this test or

surgery, length of stay will be decreased and further treatment or testing avoided.

4. Work together with other members of the medical staff. There is strength in numbers. The hospital administrator or a third party payor will be much more impressed with ten physicians' desires than with one physician's request.
5. Cooperate with your peers and be able to delay gratification at times. Today, I'll support you. Tomorrow, you can help me. This year you are hungriest and get the biggest piece of the pie; next year, I'll get the biggest piece of the pie.
6. If you are angry, wait 24 hours to deal with the problem. Don't act impulsively. Plan your approach. Whenever possible, discuss your plans with other members of the medical staff ahead of time to obtain their support and answer their questions before presenting a proposal. You cannot predict reactions or expect people to act on complicated issues if they have not had time to study



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***“Just complaining will not get problems solved or effect needed change.”***

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- the proposal ahead of time.
7. Establish your credibility by following through on projects or proposals. Do what you say you will do.
  8. There is no substitute for persistence.
  9. Finally, realize you are dealing with people — people who have feelings and emotions, fears, anxieties, insecurities, employers and bosses to whom they are accountable. Explain that you need their support and ask for their help rather than demanding it. Balance the criticism with positive feedback when possible. Acknowledge help when given.

In summary, I think we'd all rather be a hammer than a nail. It is not enough that physicians are intrinsically bright, creative, resourceful beings. We must strengthen our ability to define goals, negotiate, and pull together, sometimes relinquishing self-interest and short-term gains to effect significant long-term change.

**Jannice O. Aaron, MD**

## The "Pro-Active" Physician: An Open Letter

**T**O THE EDITOR: Practicing physicians differ widely with respect to their relationships to the state peer review organization. This article examines some of these relationships and discusses ways in which individual practitioners may influence PRO function and policy.

Some physicians have never truly accepted peer review as an integral part of the health care delivery system. These physicians may have a "passive" involvement with the peer review organization, that is, they find themselves involved in a process of which they have little understanding. Lack of knowledge as to the purpose and procedures of peer review hampers these individuals in their responses to peer review inquiries, which they may even choose to ignore. The resultant lack of communication engenders an antagonistic, counterproductive relationship which is detrimental to all involved parties — physician, PRO, and patient.

An alternative to the passive involvement discussed above is a relationship which could best be described as "defensive." Physicians assuming this defensive posture have sometimes educated themselves as to PRO policy and procedure. Some of these individuals may even have taken the initiative to be trained as PRO reviewers (Physician Advisors). However, the primary motivation behind these efforts is the desire of the physician to protect his own practice against any perceived deleterious effects of a PRO inquiry.

While this relationship is a constructive step beyond that of passive involvement, physicians engaged in primarily defensive behavior may not perceive PRO activity as an opportunity to address broader issues of utilization review and quality assurance. It is those physicians that are most active within the peer review organization — the "PRO-active physicians" — who are most able to contribute to positive developments in medical peer review.

Who are these "PRO-active physicians"? These are individuals who, while maintaining an active medical practice, are engaged in one or more aspects of the peer review process. Most of these practitioners serve as physician reviewers in order to monitor and have input into the peer review process itself. Through the forum afforded by PRO-sponsored seminars for medical reviewers, these individuals help make the peer review organization aware of the needs and concerns of the medical community. Beyond these activities, "PRO-active physicians" also serve as panel and Committee members to address utilization, quality, and sanction issues. They play an active role in the drafting and application of precertification criteria, determination of quality issues, and the formulation of educational interventions for practitioners or institutions with confirmed deficiencies in the delivery of medical care.

Physicians who maintain a high profile in PRO functions are able, as a group, to influence Medicare quality

assurance on a regional and national level. In a recent development, the Health Care Financing Administration was persuaded to modify its position on the assignment of quality issues with respect to certain groups of nosocomial infections. This change in policy, acknowledged by nearly all physicians as a positive development, would have been delayed or possibly never achieved were it not for the concerted efforts of "PRO-active" physicians at all levels of the medical review process.

Future developments in Medicare peer review include a greater reliance on large scale data management and statistical analysis for the identification of utilization and quality issues. Continued physician involvement is essential to assure that any statistical model used to evaluate medical care is scientifically valid. Furthermore, the information obtained through the manipulation of large data bases must be used to enhance, not limit, the growth of medical knowledge and the availability of new technology. To keep pace with the demands of the present and to face the challenges of the future, the medical profession clearly needs more "PRO-active" physicians. To those already so involved, I wish to convey my sincere thanks. To those who are able to give of their time and effort, please consider this article an invitation to become active in the Sentinel Medical Review Organization.

**David T. Tao, MD**





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## The AKMA Connection

*The following is the inaugural address given April 23 by Pam Blackstone, Owensboro, as she assumed the presidency of the Auxiliary to the Kentucky Medical Association.*

***“The one thread that joins us all in membership of the Auxiliary is the fact that we are physician spouses. The Auxiliary provides a ‘connection’ or an opportunity for every individual physician spouse to make a contact with someone who has similar goals or concerns.”***

**U**nity — Volunteerism — Public Relations — Commitment — Togetherness — A Positive Image — Pride in Medicine. These are all terms and phrases that our leaders have used the last few years to describe their hopes and dreams, not only for the Auxiliary, but for medicine itself. Instead of trying to create another focus area for the upcoming year, I have decided to try to continue an emphasis of these thoughts — to put them together; to show how we all interact or connect; to emphasize our:

### AKMA CONNECTIONS

Our first AKMA Connection is our connection to the KMA. As an Auxiliary to the Kentucky Medical Association, it is our mission to assist and to be supportive of the programs of the KMA. Efforts are continually made by the Auxiliary to stay informed of the focus areas of the Medical Association.

The assistance the KMA provides in planning our Day at the Capitol has helped make our efforts more effective and has kept our members well informed. The participation in our efforts in support of medical education

through AMA-ERF and the positive promotion of the Auxiliary by the leadership of the KMA help make our efforts worthwhile.

And finally, the financial support of the KMA as well as the support services of the staff allow the Auxiliary to continue to provide quality projects and programs for our members.

Our next connection is with the AMA Auxiliary. Our involvement in the federation of county, state, and national auxiliaries affords us the opportunity to join with over 70,000 other members throughout the nation to promote health.

The leadership training and program materials available to us through the American Medical Association Auxiliary provide countless resources to enhance our programs. Our participation in AMAA-sponsored training sessions and the valued assistance we receive from AMA Auxiliary chairmen and committee members help us maintain a high standard of member services.

The third AKMA Connection is our county connection. The state auxiliary provides training and assistance, but the impact of our



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***“It is the goal of the Auxiliary to promote health and to serve as an advocate for medicine. With the constant changes in the health care system, it is increasingly important for those affected, and those who care, to stay informed. The Auxiliary Connection provides a method to maintain that awareness.”***

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volunteer efforts is found at the county level of the federation.

From Ashland to Paducah — from Louisville to Somerset, communities throughout the Commonwealth are benefitting from the programs of the component auxiliaries of the AKMA.

Layette programs, health care days, and seat belt promotion; drug and alcohol awareness programs and homeless projects; blood drives, bicycle helmet safety promotion, and school-based health information programs are providing Kentuckians with accurate and important health care information.

County auxiliaries are spending countless hours promoting healthy lifestyles and providing valuable information to the citizens of their communities.

The fourth connection of the AKMA is our connection to each

member's personal medical “connection.” The one thread that joins us all in membership of the Auxiliary is the fact that we are physician spouses. The Auxiliary provides a “connection” or an opportunity for every individual physician spouse to make a contact with someone who has similar goals or concerns.

There is no longer a stereotype to fit the physician spouse. The professional spouse, the at-home

spouse, the office spouse, and the physician-physician couple provide a diverse group of individuals who all have a common bond — an interest and a commitment to the field of medicine.

It is the goal of the Auxiliary to promote health and to serve as an advocate for medicine. With the constant changes in the health care system, it is increasingly important for those affected, and those who care, to stay informed. The Auxiliary Connection provides a method to maintain that awareness. From the KMA — to the AMA Auxiliary — to the county auxiliaries — to the individual physician spouse — The AKMA CONNECTION is here for every physician spouse.

**Pam Blackstone**  
**AKMA President**

## MAY

**17-18 — Low Back & Sciatic Pain: Evaluation and Treatment.** Presented by Washington University School of Medicine. Contact: Cathy Caruso, Office of CME, Washington University School of Medicine, 660 S Euclid, Box 8063, St Louis, MO 63110, 314/362-6893.

**17-18 — Annual Meeting, The Virginia Society of Otolaryngology — HNS,** Omni Waterside Hotel, Norfolk, VA. Contact: Donna Scott, 4205 Dover Rd, Richmond, VA 23221, 804/353-2721.

**18 — Nephrology Seminar,** University of Louisville Health Sciences Center Auditorium, Louisville, KY. Contact: Laura Tucker, CME, University of Louisville, Louisville, KY 40292; 502/588-5329.

**19-24 — Twenty-Second Family Medicine Review — Session II;** Hyatt Regency Hotel, Lexington, KY. Contact: Ms Joy Greene, Director CME, 132 College of Medicine Office Bldg, U of K, Lexington, KY 40503-0086; 606/233-5161.

## JUNE

**12-15 — American Academy of Family Physicians,** Kentucky Chapter, Annual Meeting, Galt House, Louisville, KY. Contact: Gayle Knopp, 502/451-0370.

**13-14 — Cardiology in Practice,** Hyatt Hotel on Capitol Square, Columbus, OH. Contact: Ohio State University, 800/492-4445.

**13-15 — 36th Great Smoky Mountains Pediatric Seminar,** Park Vista Hotel, Gatlinburg, TN. Contact: The University

of Tennessee Department of CME, 1924 Alcoa Hwy, D-116, Knoxville, TN 37920; 615/544-9190.

**17-21 — Thirteenth Family Medicine Review,** Hyatt Regency Hotel, Louisville, KY. Contact: Laura Tucker, CME, University of Louisville, Louisville, KY 40292; 502/588-5329.

**19-23 — Southern Association for Geriatric Medicine 1st Annual Spring Meeting,** Hotel Vancouver, Vancouver, British Columbia. Contact: Robin Buchanan; 205/945-8425.

**28-30 — (Urologists Only) — Frontiers in Endosurgery,** Washington University Medical Center. Contact: Cathy Caruso, Office of CME, Washington University School of Medicine, 660 S Euclid, Box 8063, St Louis, MO 63110; 800/325-9862.

## JULY

**20-27 — 9th Annual Medical Seminar at Plummer's Great Slave Lake Lodge,** Northwest Territories, Canada. Topics in Contemporary Medicine. All specialties. Category 1-23 approved CME credits. Sponsored by North Memorial Medical Center and the University of Minnesota Department of Family Practice and St John's Regional Health Center, Springfield, MO. Contact: 612/588-9478.

**31-August 4 — Southern Association for Oncology 4th Annual Meeting,** Crystal Palace Resort and Casino, Nassau, Bahamas. Contact: Southern Association for Oncology, 205/942-0530; or SMA Travel, 800/423-4992.

## AUGUST

**7-11 — Southern Orthopaedic Association 8th Annual Meeting,** The Broadmoor, Colorado Springs, CO. Contact: Southern Orthopaedic Association, 205/945-1848.

## SEPTEMBER

**14 — Lasers and Beyond,** presented by N. D. Radtke, MD, and Humana Hospital Audubon. Category I credit. Contact: N. D. Radtke, MD, 240 Audubon Medical Plaza, Louisville, KY 40217; 502/636-2823.

## OCTOBER

**27-November 1 — Twenty-Second Family Medicine Review — Session III;** Hyatt Regency Hotel, Lexington, KY. Contact: Ms Joy Greene, Director CME, 132 College of Medicine Office Bldg, U of K, Lexington, KY 40503-0086; 606/233-5161.

## NOVEMBER

**4-8 — 57th Annual Scientific Assembly of the American College of Chest Physicians,** San Francisco Marriott and the Moscone Center, San Francisco, CA. Contact after June 20, 1991: American College of Chest Physicians, Division of Education, 3300 Dundee Rd, Northbrook, IL 60062-2348; 708/498-1400.

**16-19 — Southern Medical Association's Annual Scientific Assembly,** Georgia World Congress Center and Atlanta Hilton and Towers, Atlanta, GA. Contact: SMA, 800/423-4992.





*America's Best of Show:*

*Lexington*  
KENTUCKY

**W**hether you see horses grazing in the lush fields of bluegrass or cheer them on as they thunder past the finish line, you will discover why Lexington has the reputation as the “**Horse Capital of the World.**”

The historical link to horses dates back to the 1700s when thoroughbreds from England and Virginia were brought to Lexington. By 1780, the first race path was established and many horse races were held on what is now South Broadway Street. During the middle

1800s, Lexington's reputation for breeding champions was well established and the Bluegrass Region had produced its own contribution to the horse world, the American Saddle Horse.

#### **KEENELAND RACE COURSE**

— “Racing as it was meant to be” truly does describe Keeneland, the best of the best in thoroughbred race courses. Enjoy “early morning workouts” at trackside spring through fall. Walk down to the rail and watch the thoroughbreds go through their

early morning exercises and then have breakfast at the track kitchen where you can sample a traditional Kentucky breakfast.

#### **KENTUCKY HORSE CENTER**

— See thoroughbreds up close as you enjoy an escorted tour of a working thoroughbred training facility. During the 1½ hour tour, you step into a historic barn, stand by the rail of the one-mile training track during morning workouts, admire mares and foals in the pasture, observe normal



work day activities on the backside, and relax in the 920-seat sales pavilion while you learn the history of the thoroughbred and thoroughbred racing.

**KENTUCKY HORSE PARK** — The horse is king at this 1,032-acre park, located just 15 minutes from downtown Lexington. Attractions include a popular Horse Museum, films, the \$3 million collection of Calumet Farm racing trophies and statue of Man O' War. Youngsters of all ages enjoy the daily Parade of Breeds (nearly 100 different kinds of horses). Pet a foal, meet a Clydesdale, ride a carriage or a hay wagon. Enjoy the many exhibits, events, museums, demonstrations, restaurant, gift shop, and of course, horses!

**AMERICAN SADDLE HORSE MUSEUM** — Located on the grounds of the Kentucky Horse Park, the museum is dedicated to the oldest

registered American horse breed — the American Saddle Horse. The museum colorfully portrays the heritage, traditions, and excitement of the American Saddlebred Horse and offers a contemporary and classy review of the horse's versatility and companion uses. Attractions include: multi-image theater presentation telling the story of the American Saddlebred; video scrapbook showing the World Champions; exhibit allowing visitors to see how they look riding various American Saddlebreds; a computer giving visitors information on Saddlebred horses in their state and testing their knowledge on the Saddlebred Game; and a gift shop featuring unique gift items and souvenirs.

**POLO MUSEUM AND HALL OF FAME** — This museum, also located at the Kentucky Horse Park, features US Polo memorabilia, art, a national trophy collection, and an extensive library.

**RED MILE HARNESS TRACK** — Lexington's Red Mile has been a focal point for the fast-growing sport of standardbred racing for the past century. The red clay track at the Red Mile is reputedly the fastest track in the world — the site of more records for trotters and pacers than any track elsewhere.

**SPENDTHRIFT FARM** — Home of Triple Crown winner Affirmed and one of the most successful thoroughbred farms in the world. Tour the farm and get a close-up view of the daily activities of a major thoroughbred breeding farm where more than 35 stallions of national prominence stand.

While horses are synonymous with Lexington, there are still many other sterling qualities to be discovered about this famous region of the state, several of which we will share with you in future issues of the *Journal*. *kma*

# Prevention:

## Rx for Health Care in the 90s

*KMA Annual Meeting · Sept 29 - Oct 3*  
*Hyatt Regency Hotel · Lexington, KY*



## Nominations Being Accepted for Three Annual KMA Awards

**N**ominations are being accepted for three awards which are presented each year at the KMA Annual Meeting to outstanding physicians and lay people.

The *Distinguished Service Award* is presented each year to a physician in the state who has contributed to organized medicine or individual medical service, community health or civic betterment and medical research or distinguished voluntary military service. The nominee may qualify on any one or a combination of these points.

The *Kentucky Medical Association Award* is presented to an outstanding lay person in honor of his or her outstanding accomplishments in the field of public health and/or medical care. Recipients of the Distinguished Service Award and the Kentucky Medical Association Award will be chosen by the Awards Committee. **July 15** is the deadline for receiving nominations for these awards.

Nominees for the *Educational Achievement Award* are chosen from citizens of the Commonwealth of

Kentucky who have made a significant contribution in medical or medically related education. Contributions in all areas of teaching, research, clinical application of medical practice and/or patient education are factors that will be considered. Recipients are chosen by the Continuing Medical Education Committee. **July 1** is the deadline for receiving nominations for the Educational Achievement Award.

Nominee material should include background and historical information about the nominee as well as justification for the nomination. kma

This space contributed as a public service.



# AWARDS NOMINATIONS

The KMA Awards Committee is accepting nominations for the two highest awards the Association presents. The Distinguished Service Award is presented annually to a member of the Association based on the following criteria:

- Contributions to organized medicine (including membership in county society, attendance of county and state meetings, service on committees, leadership as an officer, etc.)
- Individual medical service
- Community health, education and civic betterment
- Medical research

The nominee may qualify on any one or all combinations of these points. Reasons for the nominations should be clearly stated.

The Kentucky Medical Association Award is presented to an outstanding lay person in Kentucky each year in honor of his or her outstanding accomplishments in the field of public health and/or medical care.

The Awards Committee will have the responsibility to choose recipients of the KMA Distinguished Service Award and the Kentucky Medical Association Award. Any county society or individual member may suggest nominees to the committee.

The awards are presented at the President's Luncheon during the annual meeting.

## AWARD NOMINATION FORM

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Place: \_\_\_\_\_

Marital Status: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_

Children: \_\_\_\_\_

☐ Distinguished Service  
Award (Physician)

☐ KMA Award  
(Lay Person)

Education: \_\_\_\_\_

Military: \_\_\_\_\_

Membership in Professional Organizations: \_\_\_\_\_

Membership in Civic Organizations: \_\_\_\_\_

Honors and Awards: \_\_\_\_\_

(Describe nominees qualifications and other pertinent information which the Awards Committee may consider in making its decision.)

Name of Person or Group Submitting Nomination: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: (Home) \_\_\_\_\_

(Office) \_\_\_\_\_

Please fill in and mail to: KMA, Attn: Awards Committee, 3532 Ephraim McDowell Dr, Louisville, KY 40205

Deadline for receiving nominations is July 15.



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## PEOPLE

**Paul A. Fleitz, MD**, has been elected president of the Methodist Evangelical Hospital Medical Staff. **R. John Ellis, Jr, MD**, is president-elect, **John A. Van Arsdall, MD**, is secretary-treasurer, and **John D. O'Brien, MD**, is past president. Other officers include: **Robert G. Hammer, MD**, chief of medicine; **A. O'tayo Lalude, MD**, chief, department of family practice; **Robert W. Linker, MD**, chief, department of surgery; **William H. Powers, Jr, MD**, chief, department of gynecology; **W. Neale Bennett, MD**, chief, department of anesthesiology; **Jerry B. Buchanan, MD**, chief, department of radiology; **Charles T. Lucas, MD**, chief, department of pathology; and **Alexander T. Thomas, MD**, chief, department of emergency medicine.

**Hoyt D. Gardner, MD**, was named a 1991 Alumni Fellow of the University of Louisville School of Medicine at ceremonies recently held in the new University Club and Alumni Center, Belknap Campus.

Four times a year, U of L surgeon **George Nardin, MD**, takes his skills to the people of the Third World. Accompanied by eight to 25 colleagues and loading up the plane with enough medical supplies to treat hundreds of people, he "slightly" exceeds the airline's allowance for luggage. The last trip cost him \$7,000 for extra baggage.

Everything needed to treat patients is shipped from the US, including intravenous solutions and tubes, gloves, gowns, sterile drapes, bandages, mattresses, lamps, lens implants, and microscopes. The half ton of supplies sometimes includes huge quantities of sterile water.

Many of the supplies are donated

by hospitals and pharmaceutical companies. Some are purchased with donated money. Most leftover supplies remain with local doctors for follow-up care, except for instruments and equipment such as microscopes which are too expensive to leave behind.

In a matter of days, this group of ophthalmologists and their support team treat hundreds of patients. Hundreds more are turned away when the team packs up to go home. Local residents have been known to wait in line for days for the chance to be treated by an American doctor.

Invaluable experience is gained by the young doctors because they encounter diseases rarely seen in the United States. According to Dr Nardin they have had a great response from senior residents because they can work on difficult surgical cases that improve their skills and bolster their confidence as surgeons.

Many of the volunteers are or have been associated with U of L's School of Medicine, and all of them pay their own expenses for the trips.

Preparations have already begun for a September trip to Nanchang Medical University in the Jiangxi Province of central China. Dr Nardin will be accompanied by a multi-specialty team of doctors, nurses and technicians from general surgery, dentistry, obstetrics and gynecology, plastic surgery, dermatology, and anesthesiology.

Supplies are being collected and about a third of the required medical team has made a commitment to go. Dr Nardin estimates that out-of-pocket costs for medical volunteers will add up to \$2,000 each. He and three colleagues have organized a non-profit entity to administer monies donated to the cause.

Non-medical volunteers are invited to go on the trips if they are willing to provide help with tasks such as record-keeping.

To volunteer, call Dr Nardin at 502/588-5464.

The following KMA member physicians have been appointed to the staff of the University of Louisville: **Robert Acland**, additional associate appointment, physiology and biophysics; **Thomas Roy**, additional associate appointment, anesthesiology; **Mark Abram**, **Robert Burkhart**, **Forrest Calico**, **Ray Cave**, **Henry Chambers**, **Herbert Chaney**, **Michael Collins**, **Steven Green**, **Plavakeerthi Kemparajurs**, **Ronald Koff**, **Robert McClure**, **Earl Oliver**, **William Pratt**, **David Vickers**, **Ardy Wright** and **David Zoeller**, assistant clinical professors, family practice; **Timothy Spaulding**, clinical instructor, obstetrics and gynecology; and **Prem Verma**, clinical instructor, family practice. The University has also announced the following promotions: **Charles Severs**, assistant clinical professor, family practice; **Carrell Spann**, assistant clinical professor, medicine; and **Oscar Thompson**, assistant clinical professor, medicine.

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## UPDATES

### AMA Releases HIV Early Care Guidelines

The American Medical Association has mailed its members "HIV Early Care: AMA Physician Guidelines." The 16-page report was included in the March 11 issue of *American Medical News*.

Additional copies of the guidelines can be obtained from the AMA Division of Health Science, phone 312/464-5563.

### Volunteers Needed for Glaucoma Studies

The degenerative eye disease known

as glaucoma blinds thousands of people every year, and half of the people who are victimized lose their vision because the disease goes undetected. Researchers continue to search for ways to aid early diagnosis and for innovative drugs to halt the progression of the disease.

"There is no cure for glaucoma," according to the University of Louisville's **Thom Zimmerman, MD**. "The only way to fight it is by early detection."

Dr Zimmerman is professor of ophthalmology and visual sciences and chairman of the Kentucky Lions Eye Research Institute. Several new drugs are now being tested at the institute, and Dr Zimmerman is looking for volunteers willing to participate in the studies.

Participants must have been diagnosed as having glaucoma or high eye pressure, between the ages of 21 and 85, and be able to travel to the eye institute for treatment.

Volunteers must also have some useful vision in both eyes and cannot be taking beta blockers for high blood pressure. Participants will receive a thorough eye exam and will be returned to the care of their own physician when the tests are finished. The studies run from five weeks to three months.

If you are interested in participating in these studies, call Meg Fuqua at 502/588-5466.

#### **FDA Approves Leukine™ (Sargramostim)**

Immunex Corporation has announced Food and Drug Administration clearance to market Leukine™ (Sargramostim), a recombinant human granulocyte macrophage colony stimulating factor (rhu GM-CSF), which is a drug that promotes the growth of infection-fighting white blood cells. Leukine, among the first of a new class of drugs called colony stimulating factors, will be available

immediately. The drug will be used to speed myeloid (marrow) recovery in patients undergoing autologous bone marrow transplantation to treat certain cancers called non-Hodgkin's lymphoma, Hodgkin's disease, and acute lymphoblastic leukemia.

Immunex developed Leukine in collaboration with Behringwerke, AG (Marburg, Germany) and Hoechst-Roussel Pharmaceuticals, Inc (Somerville, NJ). In addition to providing the new therapy through its own medical sales representatives, Immunex will manufacture Sargramostim for distribution in the United States by Hoechst-Roussel.

### **NEW MEMBERS**

*Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.*

#### **Fayette**

**Susan M. Cox, MD** — OBG  
2566 Overlake Blvd, Lexington 40513  
1982, Baylor

**Franklin C. Miller, MD** — OBG  
787 Harbor Pl, Lexington 40502  
1962, U of Louisville

**Joseph S. Stapczynski, MD** — EM  
3315 Coldstream Dr, Lexington 40517  
1976, U of California, Los Angeles

#### **Franklin**

**Jeffrey L. Rice, MD** — FP  
30 Forly Drive, Frankfort 40601  
1978, U of Kentucky

#### **Jefferson**

**Jack E. Allen, MD** — IM  
915 Baxter Ave, Louisville 40204  
1974, U of Louisville

**James W. Boone, MD** — PD  
8911 Lippincott Rd, Louisville 40222  
1984, U of Louisville

**Susan G. Bornstein, MD** — OBG  
149 Breckinridge Sq, Louisville 40222  
1986, U of Louisville

**Joseph R. Brightwell, MD** — OPH  
3709 Stanton Blvd, Louisville 40220  
1985, U of Louisville

**Charles E. Carter, MD** — AN  
5108 Olde Creek Way, Prospect 40059  
1978, U of Kentucky

**Clara M. Cobb, MD** — PTH  
502 Tower Dr #3, Louisville 40207  
1982, U of Kentucky

**Lynell C. Collins, MD** — PUD  
1230 Vim Dr, Louisville 40213  
1983, U of Louisville

**Rhonda Elam, MD** — PD  
2113 State St, New Albany, IN 47150  
1985, U of Louisville

**Scot D. Hines, MD** — N  
3 Audubon Plaza Dr, Louisville 40217  
1985, Marshall U

**Bryan T. Iglehart, Jr MD** — EM  
702 Cannons Ln, Louisville 40207  
1979, U of Louisville

**Lonnie King, MD** — EM  
5400 Pueblo Rd, Louisville 40207  
1981, U of Louisville

**Robert E. Lee, MD** — NEP  
10839 Hobbs Station Rd, Louisville 40223  
1980, Meharry Medical College

**Mark D. Moncino, MD** — PD  
1105 Rostrevor Cir, Louisville 40205  
1984, Loyola U

**Joseph F. Seipel, MD** — N  
703 E Market St, New Albany, IN 47150  
1984, Indiana U

#### **Mason**

**Mark F. Stegman, MD** — OBG  
1350 Medical Park Dr, Maysville 41056  
1981, U of Cincinnati

#### **Northern Kentucky**

**Thomas E. Isphording, Jr MD** — PD  
1805 Alexandria Pk, Highland Hgts 41076  
1986, U of Cincinnati

**Brett V. Kettelhut, MD** — A  
18 Rainbow Lane, Alexandria 41001  
1982, U of Nebraska



**Bradley L. Miller, MD** — R  
PO Box 17630, Edgewood 41017  
1985, U of Cincinnati

#### Rockcastle

**Karen J. Saylor, MD** — PD  
PO Box 125, Brodhead 40409  
1986, U of Kentucky

#### New In-Training

##### Fayette

**C. Stephen Edwards, MD** — PD  
**Kenneth A. Thielmeier, MD** — AN

##### Jefferson

**Penny M. Adcock, MD** — IM  
**Jonathan R. Berman, MD** — PS  
**Amy M. Burrows, MD** — PTH  
**Janet R. Chipman, MD** — S  
**Mark L. Corbett, MD** — A  
**Umar M. Dukar, MD** — OPH  
**Stuart A. Eldridge, MD** — PD  
**Susan E. Janocik, MD** — IM  
**Jeanne P. Lipscomb, MD** — IM  
**Stephen P. Makk, MD** — ORS  
**Steven B. Sanders, MD** — S  
**William S. Smock, MD** — EM  
**Lisa M. Vuocolo, MD** — IM

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#### DEATH

**Denzil G. Barker, MD**  
Hopkinsville  
1916-1991

Denzil G. Barker, MD, a retired family practitioner, died March 1, 1991. Dr Barker graduated from Tulane University School of Medicine in 1942. He was a recipient of the Kentucky Citizen Doctor of the Year award, determined by a statewide vote of physicians, in 1962. Dr Barker was a life member of KMA.

## CAGE Questionnaire

For the Diagnosis of Alcoholism

**C** = Have you ever felt you should **cut down** on your drinking?

**A** = Have people **annoyed** you by criticizing your drinking?

**G** = Have you ever felt bad or **guilty** about your drinking?

**E** = Have you ever had a drink first thing in the morning (**eyeopener**)?

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Positive CAGE Answers:

1 = Suggestive 2 = Probable 3 and/or 4 = Diagnostic

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**KENTUCKY MEDICAL ASSOCIATION**  
**Committee on Impaired Physicians**  
**3532 Ephraim McDowell Drive**  
**Louisville, KY 40205**  
**(502)459-9790**

# Rural Kentucky Medical Scholarship Fund, Inc Establish Practice Grant Program

**T**he Establish Practice Grant Program has met with great success. The program was initiated by the Rural Kentucky Medical Scholarship Fund, Inc for the purpose of meeting the current medical needs of the people in critical counties. There are 33 counties classified as critical.

In addition, the program will provide educational financial assistance to physicians willing to practice in such areas. Upon completion of each year of

practice, the physicians who participate receive \$10,000 toward their educational debt for a maximum of four years for a total of \$40,000 per physician.

Presently, Jerry Jamison, MD, is practicing in Russell County. Gary Partin, MD, is practicing in Adair County. Dennis Campbell, MD, is practicing in Knott County and Matthew Stiles, MD, is practicing in Menifee County. The EPGP has been expanded to offer up to five grants annually,

depending upon the availability of funds.

If anyone is interested in this worthwhile program, please contact the RKMSF Office, 3532 Ephraim McDowell Drive, Louisville, 40205; telephone: 502/459-9790.

The annual meeting of the Board of Directors of the Rural Kentucky Medical Scholarship Fund, Inc is scheduled for Thursday, May 16, 1991, at KMA Headquarters.

*kma*

## **KMA Member . . . Auxilian . . .**

Our readers are interested in the important events occurring professionally in the lives of their fellow members. Do you, or someone you know, have a newsworthy note to submit for possible publication in your *Journal of the KMA*?

If so, please submit in writing to:

**KMA Journal  
3532 Ephraim McDowell Drive  
Louisville, KY 40205**



# PARTICIPATING PHARMACIES

## KPC PHARMACY PROVIDER PROGRAM

**Adair**  
DBA Columbia Pharmacy  
Madison Square Drugs & Chymist

**Allen**  
Carpenter Dent Drugs  
Stovall Prescription Shop  
Williams Pharmacy

**Andersan**  
The Medicine Shoppe

**Barren**  
Ely Drugs, Inc.  
Glasgow Prescription Center  
Towne & Country Drugs

**Bell**  
Farris Drugs  
Jeff's Pharmacy  
Kroger Company  
Pineville Hos. Out-Pt Pharmacy  
SuperX Drugs  
Total Rx Care Pharmacy

**Baane**  
Baane County Drugs  
Burlington Pharmacy  
SuperX Drugs  
Turfway Pharmacy

**Baurban**  
Glen's Drugs  
Harne's Ardrey Drug  
The Medicine Shoppe

**Bayd**  
McMeans Pharmacy  
SuperX Drugs

**Bayle**  
Grider Pharmacy  
Leake Pharmacy  
SuperX Drugs  
Taylor Drug

**Bracken**  
Dean's Pharmacy

**Breathitt**  
Jackson Prescription Ctr

**Breckinridge**  
Save-Rite Drugs  
Tawne & Country Pharmacy

**Bullitt**  
Taylor Drugs

**Caldwell**  
Payless Discount Pharmacy  
The Pharmacy Corner Enterprise

**Callaway**  
Clinic Pharmacy  
Holland Drugs  
Safe-T Discount Pharmacy  
Walter's Pharmacy

**Campbell**  
Alexandria Drugs  
Martin's Pharmacy  
Newport Drug Center  
SuperX Drugs

**Carrall**  
Parklane Pharmacy  
Webster Drugs

**Carter**  
Horton Brother & Brown  
Rose Pharmacy

**Christian**  
Express Pharmacy  
Horn Prescription Shop  
Jennie Stuart Medical Center  
Save More Drug  
The Medicine Shoppe

**Clark**  
Carner Drug Store  
Day Drugs  
SuperX Drugs

**Clay**  
Family Drug Center  
H & N Drug  
Medi Center Drugs

**Crittenden**  
Glenn's Apothecary

**Cumberland**  
Smith Pharmacy

**Daviess**  
Danhauer Drug Company  
Emery Centre Pharmacy  
Greene's Pharmacy  
Harrell's Drug Store  
Mayfair Pharmacy  
Medical Plaza Pharmacy  
Medicine Shoppe  
Nation's Medicines  
Taylor Drug #21  
Wal-Mart Pharmacy

**Edmansan**  
Prescription Shop

**Fayette**  
Hi-Acres Pharmacy  
Hubbard & Curry Pharmacy  
Hutchinson Drug  
All Krager Pharmacies  
Professional Arts Apothecary  
Randall's Pharmacy  
Taylor Drugs  
The Medicine Shoppe  
Warehouse Drugs  
Woodhill Pharmacy

**Fleming**  
Plaza Pharmacy

**Flayd**  
Archer Clinic Pharmacy  
Betsy Layne Pharmacy  
Mud Creek Clinic Pharmacy  
Our Lady Of The Way Hospital

**Franklin**  
East Side Pharmacy  
Fitzgerald Drugs  
Kroger Pharmacy  
Medicine Shoppe  
Taylor Drugs  
The Prescription Center

**Fultan**  
City Super Drug  
Evans Drug Company  
Rumfelt Drug  
SuperX Drugs

**Garrard**  
Sutton Pharmacy

**Grant**  
Grant County Drugs

**Graves**  
Stanes Drugs  
SuperX Drugs  
Wilson Rexall Drugs

**Graysan**  
Clarkson Drug Store

**Green**  
Madel Drug Store

**Greenup**  
Scott Drugs  
Stultz Pharmacy

**Hardin**  
Jeff's Prescription Shop  
Kroger Company  
Showers & Hays Drugs  
SuperX Drugs  
Taylor Drugs

**Harlan**  
Lynch Med. Services Pharmacy  
SuperX Drugs

**Harrison**  
Eastside Pharmacy Of Cynthiana  
Lee Drugs

**Hart**  
Branstetter Pharmacy  
Clarks  
Mallory Drugs

**Hendersan**  
Dunoway's Imperial Pharmacy  
T & T Drugs

**Henry**  
Cook's Pharmacy

**Hapkins**  
Earlington Pharmacy  
Family Drugs  
Madisonville Pharmacy  
Nation's Medicines  
Professional Drugs #2  
SuperX Drugs

**Jackson**  
Annville Pharmacy  
Clinic Pharmacy

**Jefferson**  
Alliant Health System Pharmacy  
Art Jacob Prescription Shoppe  
Brawn, J. Graham  
Cancer Center  
Colonial Drugs  
Cox's Pharmacy  
DBA Hometek Pharmacy  
Harding Pharmacy  
Haldaway Drugs  
Hume Pharmacy  
Koby Drug Company  
All Krager Pharmacies  
Oak Drug Company, #1  
Rauben's Pharmacy  
St. Denis All Care  
All SuperX Drugs  
All Taylor Drugs  
Union Prescription Center  
Wal-Mart Pharmacies  
Warehouse Drugs

**Jessamine**  
Drug Mart  
Medicine Shoppe  
Taylor Drugs

**Jahnsan**  
Bi-Rite Pharmacy

**Kentan**  
Blank's Pharmacy  
Baekley Drugs  
Cherakee Drug Shoppe  
Crestville Drugs  
Farrell Pharmacy  
Fort Mitchell Drug Shoppe  
Fort Mitchell Pharmacy  
Ludlow Drugs  
Medical Village Pharmacy  
Morwessel Drugs  
Nie's Independence Pharmacy  
Save Discount Drugs  
All SuperX Drugs

**Knox**  
Knox Professional Pharmacy  
Sov-Rite Pharmacy

**Laurel**  
Family Drugs  
Kelley's Medical Arts Pharmacy  
Laurel Heights Nursing Home  
Landon City Drug Co.  
London-Carbin Pharmacy  
SuperX Drugs

**Lee**  
Stufflebean Pharmacy  
Three Forks Apothecary

**Letcher**  
Parkway Pharmacy  
Shapwise Pharmacy

**Lincoln**  
Coleman's Drug Store  
Rishie Drugs

**Livingston**  
Glenn's Prescription Center

# PARTICIPATING PHARMACIES

## KPC PHARMACY PROVIDER PROGRAM

**Logan**  
Gower Drug Store  
Riley-White Drugs  
Wal-Mart Pharmacy

**Madison**  
Bereo Hospital Out-Patient  
Kroger Company  
SuperX Drugs

**Mogoffin**  
Clinic Pharmacy

**Marion**  
Pot's Pharmacy  
Southall Pharmacy

**Marshall**  
Benton Discount Pharmacy  
Droffenville Pharmacy  
J & R Pharmacy  
Nelson VoluRite Pharmacy  
Poy-N-Save Discount Drugs

**Mason**  
Medical Arts Pharmacy  
Toncroy Mortar & Pestle

**McCracken**  
Davis Drugs  
Kotterjohn Drug Store  
Kroger  
SuperX Drugs  
The Medicine Shoppe

**McCreory**  
Burgess Drug Store  
Daugherty Drugs

**Meade**  
Riverview Pharmacy

**Mercer**  
Kroger Company  
SuperX Drugs

**Metcalfe**  
Metcalfe Drugs  
Nunn Drugs

**Montgomery**  
Calico & Whitt Drug  
Emil W. Baker, Pharmacist  
Ross Drugs  
SuperX Drugs

**Muhlenberg**  
Beechmont Pharmacy  
Clinic Pharmacy

**Nelson**  
Snider Drugs

**Nicholas**  
Corlisle Drug

**Ohio**  
L. L. Bone Pharmacy  
Rice Drug Store  
Spinks' Pharmacy

**Oldhom**  
Taylor Drugs

**Owsley**  
Owsley Prescription Center

**Pendleton**  
Moreland Drug

**Perry**  
L. B. Clinic Pharmacy  
SuperX Drugs  
Vicco Pharmacy

**Pike**  
Medical Pharmacy  
Nichols Apothecary  
SuperX Drugs

**Puloski**  
Brown's Bogle Street Pharmacy  
Kroger Company  
Somerset Pharmacy  
SuperX Drugs  
The Medicine Shoppe  
Tibbals Drug Store  
Wal-Mart Pharmacy

**Rockcastle**  
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Interested parties call or send CV to:

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in America.

Source: Bureau of Labor Statistics

A message from The American Medical Association  
for the Health Access America Proposal

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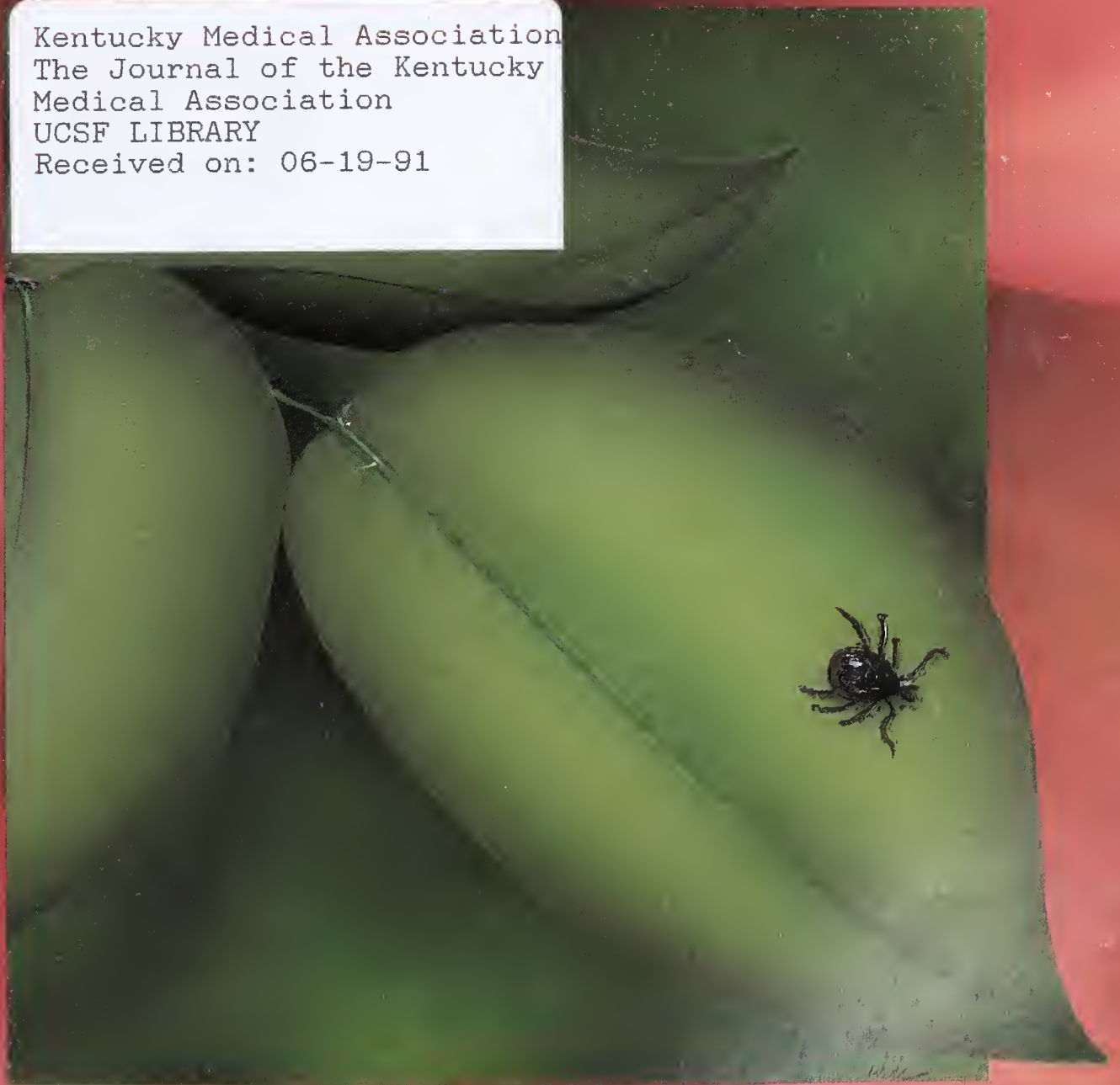
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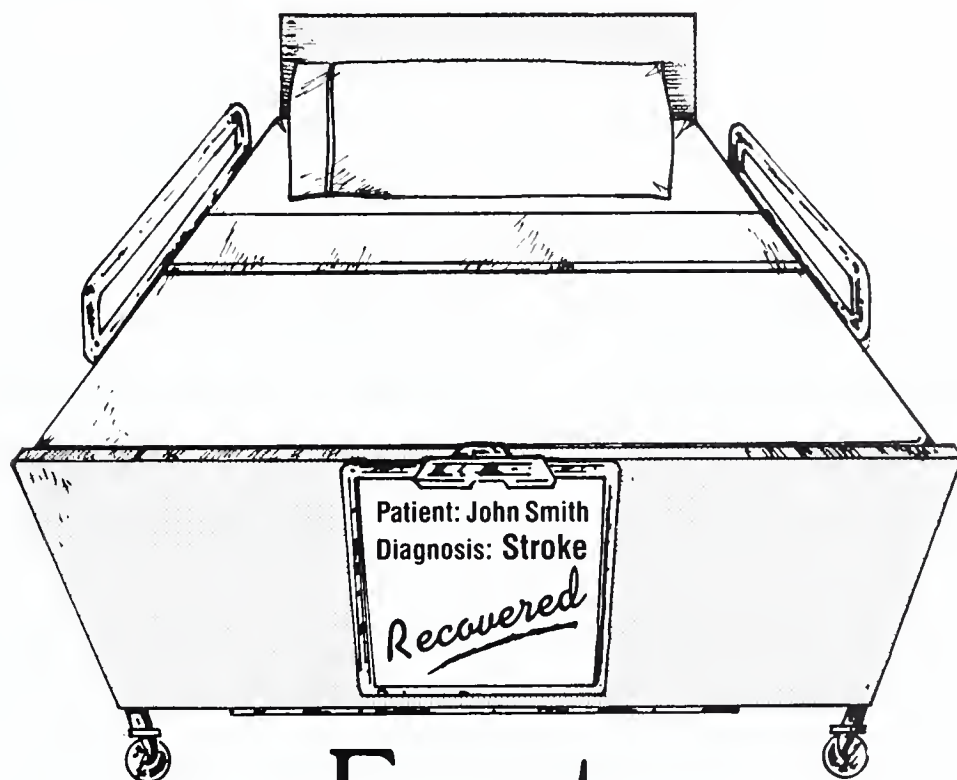
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# **Pfizer Pharmaceuticals Recommits to Make Products Available to Kentucky Physicians Care Patients**

**P**fizer Pharmaceuticals, the first major manufacturer to make products available to KPC patients through the Kentucky Pharmacy Providers program, recently announced its commitment to continue providing its full product line for at least another year. This announcement was made by Pfizer Pharmaceuticals Vice President, Charles L. Hardwick, at a press conference held on April 17, 1991, at the Lieutenant Governor's mansion in Frankfort. Mr. Hardwick stated:

"I am pleased to announce that Pfizer Pharmaceuticals will renew its commitment for another year's participation in the Kentucky Health Care Access Program. Based on our experience during the past nine months, we are convinced that this private, voluntary program does indeed respond to an important need for those patients who are without public or private health insurance and who cannot afford to pay for health care.

Our commitment is to continue to make our entire outpatient product line available at no cost, and our commitment will continue at least until June 1992.

Based on our observations, Kentucky is unique and its residents fortunate to have the political and medical leadership necessary to make such an extensive voluntary program work. Kentucky's success is due to the strong, effective political leadership of Lieutenant Governor Brereton Jones, exemplary public service by the Kentucky Medical Association under the leadership of Past President, Doctor Nelson Rue, and Doctor Russell Travis, Chairman of the KPC Operating Committee, and by the extraordinary public service of the pharmacy community, in which over 350 retail pharmacists are participating thanks to President Ray Bishop and the leadership of the Kentucky Pharmacists Association.

The issue of access to health care in this country is a serious one, and we think Pfizer, along with the rest of the responsible business community, as well as all healthcare providers, must work with federal and state governments to help find solutions to this pressing national problem.

In the meantime, the leaders of Kentucky have moved ahead to find a solution that works in this state. I want to salute all those Kentucky men and women who have made this program succeed — from the nurses who answer the incoming phone calls on the hotline — to the physicians who heal and the pharmacists who dispense our products — for their professionalism and success. We at Pfizer are proud to be associated with such fine people and wish everyone involved continued success as they serve the people of Kentucky."

**PLEASE REFER TO THE FOLLOWING PAGES  
FOR A LIST OF AVAILABLE  
PFIZER/ROERIG PRODUCTS  
AND A LIST OF PARTICIPATING PHARMACIES**

# Pharmaceuticals available to Kentucky Physicians Care

These Pfizer/Roerig pharmaceuticals may be prescribed and dispensed under the program:

## Pfizer Labs

Antiminth® (Pyrantel pamoate) OTC	Renese® Tablets (Polythiazide) Rx
Cortril® Topical Ointment 1% (Hydrocortisone) Rx	Renese®-R Tablets (2 mg. Polythiazide and 0.25 mg. Reserpine) Rx
Diabinese® Tablets (Chlorpropamide) Rx	Sustaire® (Theophylline anhydrous) Rx
Diabinese® Tablets Unit-Dose Pak (Chlorpropamide) Rx	Terramycin® Capsules (Oxytetracycline HCl) Rx
Feldene® Capsules (Piroxicam) Rx	Vansil™ Capsules (Oxamniquine) Rx
Feldene® Capsules Unit-Dose Pak (Piroxicam) Rx	Vibra-Tabs® (Doxycycline hyclate) Rx
Minipress® Capsules (Prazosin HCl) Rx	Vibra-Tabs® Unit-Dose Pak (Doxycycline hyclate) Rx
Minipress® Capsules Unit-Dose Pak (Prazosin) Rx	Vibramycin® Calcium Syrup (Doxycycline calcium oral suspension) Rx
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Minizide® 5 Capsules (5 mg. Prazosin and 0.5 mg. Polythiazide) Rx	Vibramycin® Monohydrate for Oral Suspension (Doxycycline monohydrate) Rx
Moderil® Tablets (Rescinnamine) Rx	Vistaril® Capsules (Hydroxyzine pamoate) Rx
Procardia® Capsules (Nifedipine) Rx	Vistaril® Capsules Unit-Dose Pak (Hydroxyzine pamoate) Rx
Procardia® Capsules Unit-Dose Pak (Nifedipine) Rx	Vistaril® Oral Suspension (Hydroxyzine pamoate) Rx
Procardia XL® (Nifedipine) Extended Release Tablets Rx	
Procardia XL® (Nifedipine) Extended Release Tablets Unit-Dose Pak Rx	

## Roerig

Antivert® (Meclizine HCl) Rx	Pfizerpen®-AS (Penicillin G procaine) Aqueous Suspension Rx
Antivert® Tablets Unit-Dose Pak (Meclizine HCl) Rx	Polymyxin B Sulfate Sterile Rx
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Atarax® Tablets Unit-Dose Pak (Hydroxyzine HCl) Rx	Sinequan® Capsules Unit-Dose Pak (Doxepin HCl) Rx
Bonine® Chewable Tablets (Meclizine HCl) OTC	Sinequan® Capsules Unit of Use Pack (Doxepin HCl) Rx
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# PARTICIPATING PHARMACIES

## KPC PHARMACY PROVIDER PROGRAM

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**Allen**  
Carpenter Dent Drugs  
Stovall Prescription Shop  
Williams Pharmacy

**Andersan**  
The Medicine Shoppe

**Barren**  
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Porkway Pharmacy  
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**Lincoln**  
Coleman's Drug Store  
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Pay-N-Save Discount Drugs

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Medical Arts Pharmacy  
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Davis Drugs  
Kotterjohn Drug Store  
Kroger  
SuperX Drugs  
The Medicine Shoppe

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Burgess Drug Store  
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### Meade

Riverview Pharmacy

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### Metcalfe

Metcalfe Drugs  
Nunn Drugs

### Montgomery

Calica & Whitt Drug  
Emil W. Baker, Pharmacist  
Rass Drugs  
SuperX Drugs

### Muhlenberg

Beechmant Pharmacy  
Clinic Pharmacy

### Nelson

Snider Drugs

### Nicholas

Carlisle Drug

### Ohio

L. L. Bane Pharmacy  
Rice Drug Store  
Spinks' Pharmacy

### Oldham

Taylor Drugs

### Owsley

Owsley Prescription Center

### Pendleton

Moreland Drug

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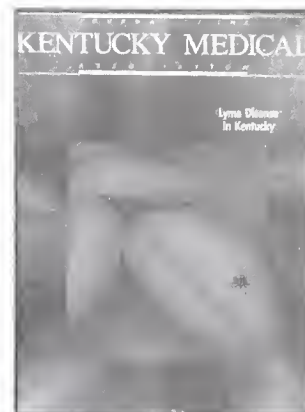


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**COVER:** Original art by Lee Wade, Louisville, introduces an article on Lyme Disease. See page 266.

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## “AMA is People”

Isn't it funny that when a negative event occurs or is reported, we automatically think of the initiating group as an “it” or “they.” It's a common human trait to use blame as a device whenever we don't want to take responsibility for something. This aphorism was never truer than when applied to our medical organizations, and particularly the AMA. The AMA is not at all a “they.” It is people. It is us.

All members of organized medicine, of the AMA, are part of the organization. The AMA does not function in a vacuum, nor does it mindlessly stumble through our medical/political lives being vaguely seen only on critical issues and only from a negative perspective. The AMA is Preston Nunnelley, and Wally Montgomery, and Paul Smith, and all the other physicians across the country who have made a collective commitment to protect our interests on a national basis and to preserve the right and dignity to practice medicine. Your AMA delegation and

all of the AMA delegations across the country that make up the AMA House of Delegates are practicing physicians, “regular people” who have the same frustrations, concerns, and elations about our profession as you do. The

only difference is that through your election, they have committed time, energy, and interest to being kept informed about national-level issues on your behalf.

At each meeting of the Board of Trustees, the delegation to the AMA gives a report and discusses major issues addressed at the most recent meeting of the AMA House. Routinely, the delegation reviews the reports of dozens of councils and committees and hundreds of resolutions. This material covers every facet of our medical lives. Although at times it seems that this material has an intangible influence on our daily practice, more often, a direct impact can be felt.

Through the efforts of the AMA, legislation is enacted and federal administrative operations are directly affected. During each budget cycle of the federal government, efforts supported by the majority in Congress are undertaken to reduce money spent on federal medical programs. During every session, these attempts

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***“The AMA is all physicians across the country who have made a collective commitment to protect our interests and to preserve the right and dignity to practice medicine.”***

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are threatened or at least somewhat diverted through the efforts of the people at AMA. Other recent examples include legislation to protect animal research facilities, bills to help defer student loan payments, proposals to reduce the harassment of physicians through insurance practices, and restriction on tobacco use in advertising. From the

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***“Cooperation and consensus occur as a result of negotiation.”***

---

administrative standpoint, the people at AMA have had recent influence on physician referrals to physician-owned clinical facilities, the diversion and recapitulation of regulations governing physician office labs, and the reinstatement of timely payment of Medicare claims. All these efforts require the cooperation of many physicians, but they were instigated and guided by the people of the AMA.

Like all organizations and all groups of people, cooperation and consensus occur as a result of negotiation. To accomplish this negotiation requires that the people of the AMA, which includes your AMA delegation, develop some medical/

personal skills beyond those skills needed to represent your scientific and clinical interests with our nationwide colleagues. Overall, our delegation is young in terms of tenure, but it has gained a measure of respect for its dedication to its responsibilities as representatives of Kentucky physicians, as well as its commitment to listen to the views of others.

To help hone these interpersonal skills and to provide a refined forum, Kentucky has joined with some 21 other states in forming the Southeast Coalition in the AMA House of Delegates. Our membership in this coalition allows us to more closely share views and ideas, reach consensus, and allows our small delegation a broader and more effective arena to broadcast our opinions. As with any federation, there is a common bond of like philosophy, but we are not bound by the rules or the voice of the group.

At AMA meetings “your” AMA people are not just your elected delegates and alternates. Our delegation is joined by the KMA officers, officers of larger county medical societies, representatives from the Young Physicians Section, the Resident Physician Section, the Medical Student Section, and the Hospital Medical Staff Section. Currently, the Governing Council of the AMA Medical Student Section is chaired by a Kentucky student, Judy Linger, and in upcoming elections, another Kentucky student, Christa Singleton, will seek a position on the Council.

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***“... the delegation reviews the reports of dozens of councils and committees and hundreds of resolutions.”***

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We have tried to keep the membership advised of our efforts on your behalf by publishing, first, articles from individual delegates on specific issues to which they are assigned, and recently, through summaries of all issues considered at a given AMA meeting. These reports, while hopefully informative, don't begin to fully touch on all of the materials or issues that we confront. There is simply not enough space to cover all of these matters. The amount of printed material given to each delegate for each meeting is measured in terms of inches, not pages. This is, however, an appropriate place to try to convey in people terms what your people at the AMA do. However, this is not a play for attention or even appreciation for what your AMA delegation actually accomplishes. It is a sincere request for your understanding that the AMA is you, and me, and us. It is people.

**Donald C. Barton, MD  
Senior Delegate to the AMA**

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# The Epidemiology of Lyme Disease in Kentucky, 1985-1990

Andrew R. Pelletier, MD; Reginald F. Finger, MD, MPH; Daniel M. Sosin, MD

From the Division of Epidemiology, Department for Health Services, Kentucky Cabinet for Human Resources, Frankfort, KY (Drs Pelletier and Finger) and the Division of Field Epidemiology, Centers for Disease Control, Atlanta, GA (Drs Pelletier and Sosin).

Reprint requests to Division of Epidemiology, 275 E Main St, Frankfort, KY 40621 (Dr Finger).

*Lyme Disease has become the most common vector-borne disease in the United States. To assess the extent of the disease in Kentucky, all case reports were reviewed for 1985-1990. A total of 51 cases met the current case definition. Epidemiologic features were similar to those reported nationally. Although the recognized tick vectors for Lyme Disease have still not been identified in Kentucky, physicians should educate their patients on the risk of Lyme Disease and measures to prevent tick bites. Reporting cases of Lyme Disease will continue to be important so that trends in the disease's occurrence in Kentucky can be monitored.*

## Introduction

Lyme Disease is now the most commonly reported vector-borne disease in the United States.<sup>1</sup> In 1989, approximately 7,400 cases were reported nationwide. However, until recently, most of these cases were from the Northeast and North Central regions of the country; few cases, with the exception of Georgia, were reported from the Southeastern United States.<sup>1,2</sup>

The public health importance of Lyme Disease in Kentucky is largely unknown.<sup>3</sup> Lyme Disease became a reportable disease in Kentucky in June 1985. To assess the extent of the disease, all case reports since that time were reviewed.

## Methods

From 1985 to 1989, the case definition for Lyme Disease in Kentucky was (1) erythema migrans and either exposure to a tick-infested area or a history of a tick bite or (2) a late manifestation of the disease (cardiac, neurologic, or rheumatic) and a significant serological titer (ELISA  $\geq$  1:128,

IFA  $\geq$  1:256, or a 4 fold or greater rise in acute/convalescent titers) in a resident of the state. Starting in 1990, the case definition was broadened to conform to the new Centers for Disease Control (CDC) definition: (1) erythema migrans or (2) at least one late manifestation and laboratory confirmation of infection.<sup>4</sup> The new case definition did not require a history of tick exposure or tick bite. Patients with erythema migrans were considered to have early signs of Lyme Disease, and those with secondary manifestations were considered to have late signs of disease.

All case reports from June 1985 through December 1990 were examined. Clinical information for patients was requested from the reporting physician. Cases were grouped by the county in which the tick bite occurred. If this was unknown, the patient's county of residence was used. Patients reporting tick exposure at Land Between the Lakes (Tennessee Valley Authority) and at Fort Campbell (United States Army) were considered to have had in-state exposure. Both areas straddle the Kentucky-Tennessee border.

## Results

A total of 118 reports of Lyme Disease were received by the Kentucky Department for Health Services. Fifty-one (43%) of these met the case definition. The number of reports and confirmed cases has been greater in recent years (Fig 1).

Twenty-four (47%) of the case patients were male. The median age was 32 years with a range from 4 to 82 years. All patients but one (98%) were white. Eleven (22%) of the patients were hospitalized for their illness. None of 27 females were known to be pregnant.

The 45 (88%) cases with exposure in Kentucky were reported from 28 counties (Fig 2). No county had more than 4 cases. The remaining 6

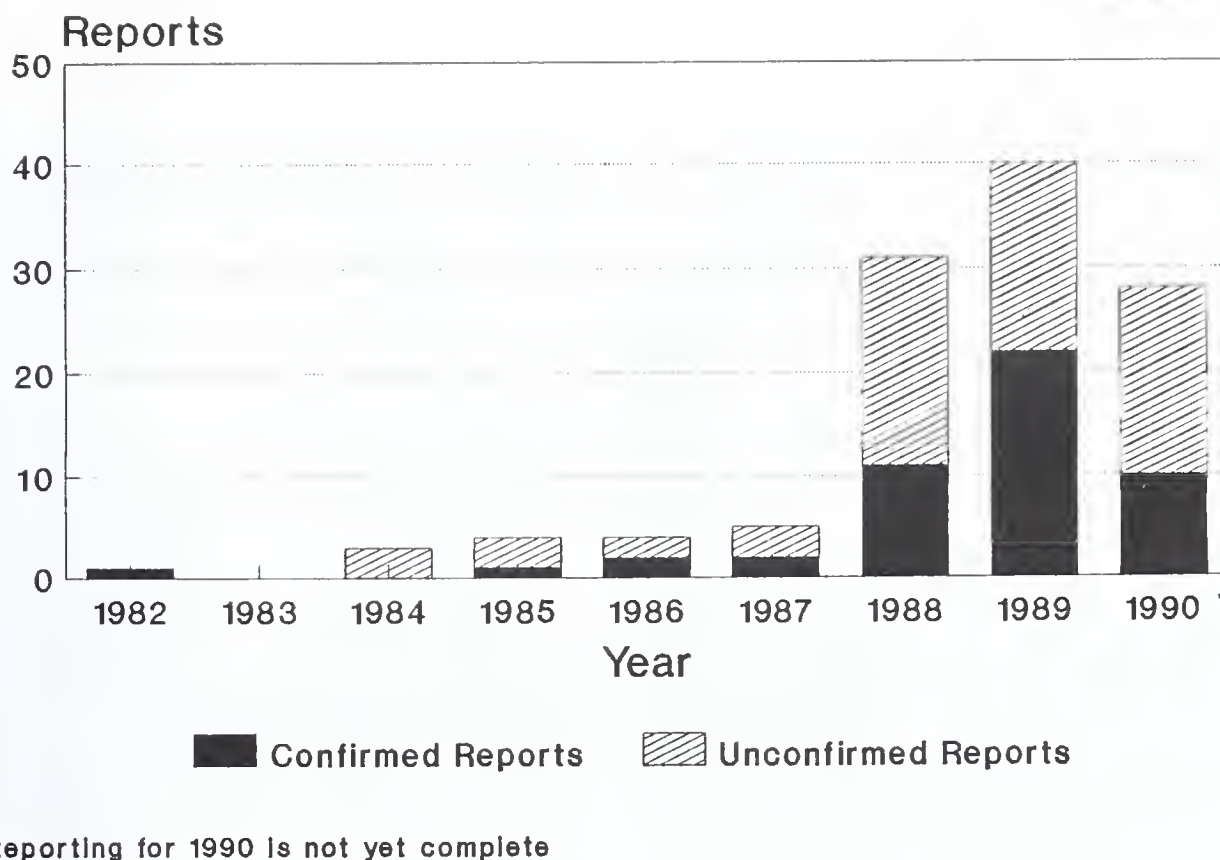


Fig 1 — Lyme Disease reports by year of onset, Kentucky, 1985-1990.

cases had a history of exposure out of the state.

Thirty-one (61%) patients reported a tick bite or tick exposure, 32 (63%) had erythema migrans, 30 (59%) had a late manifestation of the disease, and 27 (53%) had a positive serology. Thirty (59%) patients met the case definition by having erythema migrans, and 21 (41%) had a late manifestation and laboratory confirmation of infection. For those patients with a late manifestation, 28 (93%) had rheumatic complaints, 7 (23%) neurologic, and 3 (10%) cardiac. Of the 30 case-patients with early signs of disease for whom the month of onset was known, 18 (60%) became ill in May through August (Fig 3).

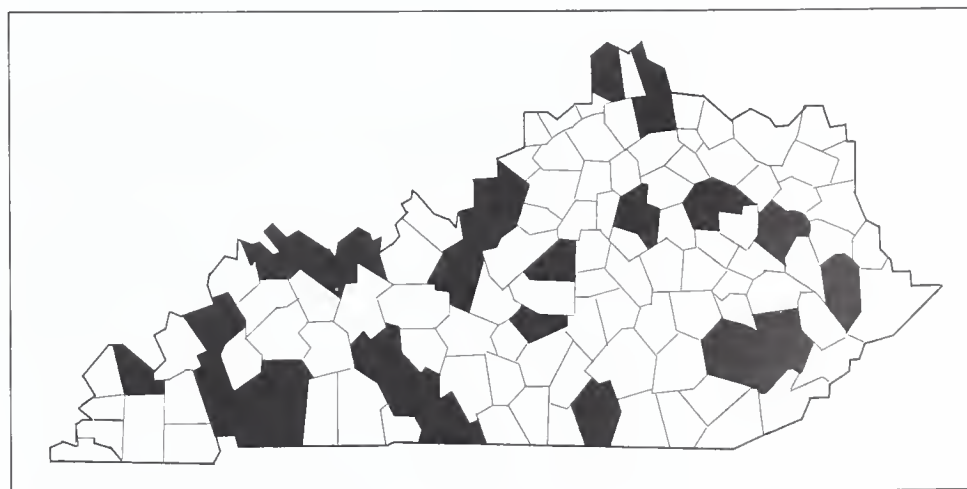


Fig 2 — Lyme Disease cases by county, Kentucky, 1985-1990.

## Discussion

The demographic features of Lyme Disease cases in Kentucky are similar to those reported nationally.<sup>1</sup> Cases occurred among all age groups and were evenly divided between males and females. Case-patients were primarily white.

More than half of the cases had early signs of the disease. Early diagnosis of Lyme Disease is important as treatment with antibiotics improves the prognosis.<sup>5</sup> All but two patients with late signs experienced arthralgias or arthritis which can be difficult to treat.<sup>5</sup>

Most reports of early Lyme Disease indicated onset of illness during the summer, which is the time of greatest tick activity. A similar trend has been reported in the northeast and north-central states, but not in the Pacific states where most cases occur during January through May.<sup>1</sup>

Comparison of the 51 cases in Kentucky over the past 6 years with case-numbers from other states was made difficult by the lack of a commonly accepted case definition prior to 1990. A survey of 16 southeastern states in 1988 (South-



## Lyme Disease in Kentucky

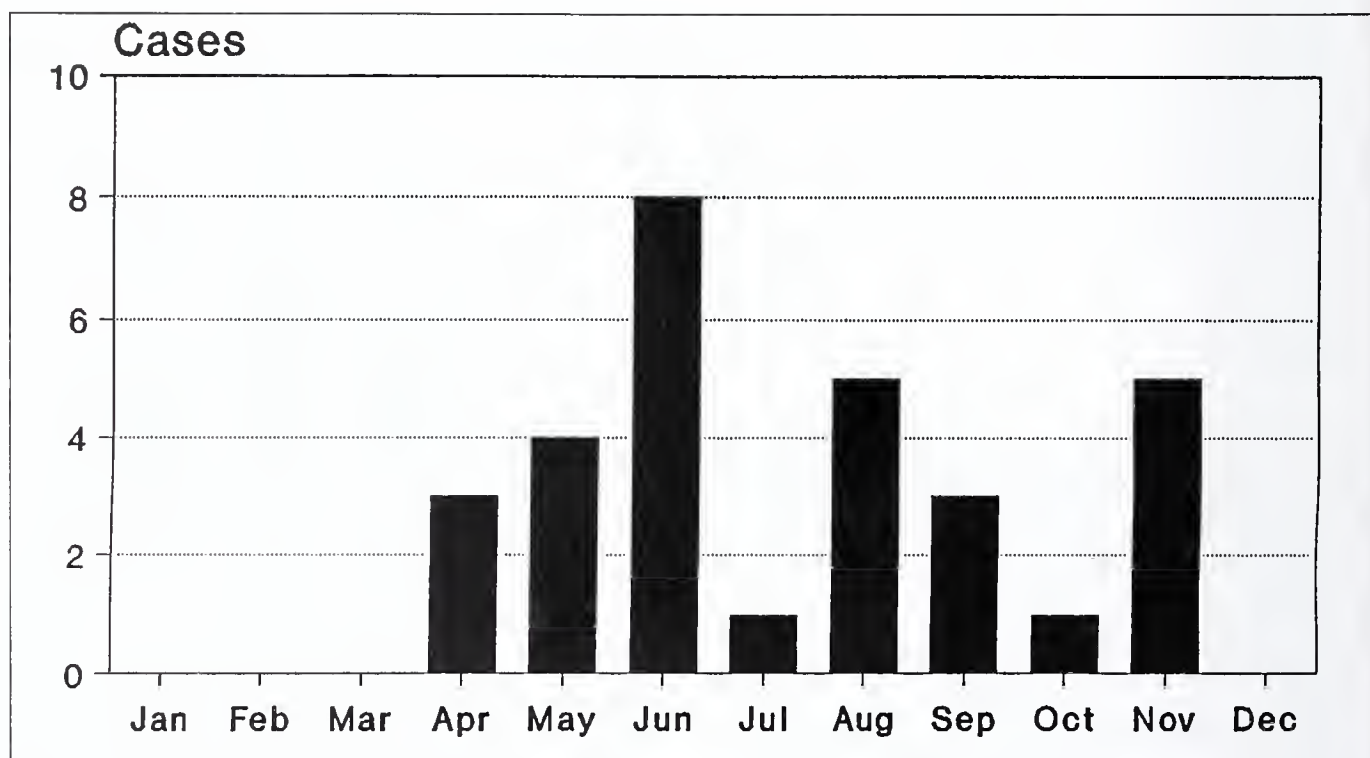


Fig 3 — Lyme Disease cases with erythema migrans by month of onset, Kentucky, 1985-1990.

eastern Cooperative Wildlife Disease Study, 1989, unpublished data) showed that only 4 states (25%) were using the old CDC case definition. The other 12 states, including Kentucky, were using a variety of case definitions. With national acceptance of the new CDC case definition, it will be possible to make direct comparisons in the number of reported Lyme Disease cases between states in the future. Because the case definition used in Kentucky before 1990 was similar to the new CDC definition, all cases of Lyme Disease previously reported in Kentucky would still be considered confirmed.

The serologic diagnosis of Lyme Disease remains problematic for three reasons. First, false negatives may occur early in the course of the disease, especially if antibiotics have been used.<sup>6</sup> Second, it is rarely possible to compare values between laboratories because of different techniques (ELISA, IFA, Western Blot) and different systems of reporting results (ratios, indices, optical densities).<sup>7, 8</sup> Third, in an area of low incidence, such as Kentucky, the predictive value of a positive test is poor. There is a great need to improve and standardize laboratory testing for Lyme Disease. Until that time, diagnosis should be based on clinical features.<sup>1</sup>

During the last few years, the number of reports and confirmed cases of Lyme Disease in Kentucky increased. Because cases are recorded by date of onset rather than date of report, the case count for 1990 is not yet complete. The increase in reported cases may be due to a combination of factors: improved surveillance, increased public awareness, and geographic spread of the disease. It is unclear how much of the increase is attributable to each of these reasons.

While the known vectors of Lyme Disease (*Ixodes dammini*, *I. pacificus*, *I. scapularis*) have not been identified in the state, it does appear that Lyme Disease transmission is occurring in Kentucky. This suggests that either *Ixodes* ticks are present, but not yet identified, or that another vector is transmitting the disease. Both *Amblyomma americanum* and *Dermacentor variabilis* are common ticks in Kentucky, however, neither one has yet been shown to be an efficient vector of Lyme Disease.<sup>9, 10</sup>

As the number of cases of Lyme Disease appears to be increasing in Kentucky, physicians need to inform their patients of the risk of Lyme Disease. Simple measures to prevent bites in tick infested areas can be taught (wearing long-sleeved shirts and long pants, tucking pants into the top

of socks, wearing light-colored clothing, inspecting clothing and skin frequently for ticks, and using repellents). Furthermore, physicians should continue reporting patients with Lyme Disease so that trends in the disease's occurrence in Kentucky can be monitored.

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# The Respiratory Complications of Leptospirosis

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*Leptospirosis is an uncommon disease. Respiratory failure attributable to this infection is unusual, but remains a major cause of mortality. Mechanical ventilation has been required for patients with significant alveolar hemorrhage and the adult respiratory distress syndrome. We report a patient with ventilatory failure due to the severe muscle weakness associated with leptospirosis and review the pulmonary consequences of this infection.*

## Introduction

Leptospirosis is a disease with world-wide distribution that is caused by spirochetes of the genus *Leptospira*. The severity of the clinical course varies from anicteric mild constitutional symptoms to the more classical manifestation with fever, jaundice, hepatitis, meningitis, nephritis and bleeding episodes. Specific clinical syndromes have not been attributed to any particular serotype. Instead, a wide variety of symptoms and signs have been reported by investigators from different parts of the world.<sup>1-4</sup>

It is recognized that pulmonary involvement may be a presenting feature in leptospirosis, but respiratory embarrassment is rarely severe enough to warrant mechanical ventilation.

When significant respiratory compromise has been observed in this disorder, it has been linked to alveolar hemorrhage or to noncardiogenic pulmonary edema.<sup>5-7</sup> These conditions interfere with gas exchange at the alveolar-capillary membrane. Affected patients may require intubation and respirator support with high fractions of inspired oxygen and positive end-expiratory pressure (PEEP) to maintain adequate oxygenation.

We report a patient with leptospirosis who developed ventilatory failure from severe progressive weakness involving his peripheral skel-

etal and respiratory muscles. The literature concerning severe respiratory problems with leptospirosis is reviewed.

## Case Report

B.W., a 62-year-old male, presented to the Louisville Veteran Administration Medical Center with a 8-day history of severe weakness, night sweats, chills, and arthralgias. Two days prior to his admission, following self-medication with tetracycline and quinine, he abruptly developed a generalized nonpruritic rash.

The patient is a widowed farmer and lives alone. He was physically active 10 days before presentation. He denied exposure to unhealthy livestock, to silage, or to chemicals. He had helped a neighbor replace a barn roof just before the weakness began. His drinking water was from a spring-fed cistern. He readily acknowledged that he frequently had to remove ticks from his body during the recent months. There had been frequent flooding of his property this spring and summer, with ground water contamination of his spring and cistern.

He was on no chronic medications and had no known allergies. He had taken quinine intermittently without problems since he was diagnosed with malaria during the Korean conflict. He had also previously consumed tetracycline on many occasions without difficulties. The patient had no history of ethanol or tobacco use.

He was mildly icteric and diaphoretic on admission. Blood pressure was normal and his respiratory rate was 16 breaths per minute. Oral temperature was 102.8°F, but his pulse rate was only 80 beats per minute. A profuse erythematous maculopapular rash that spared the palms and soles was present. Significant impairment of motor strength was documented as four fifths in the upper extremities and three fifths in the lower ex-

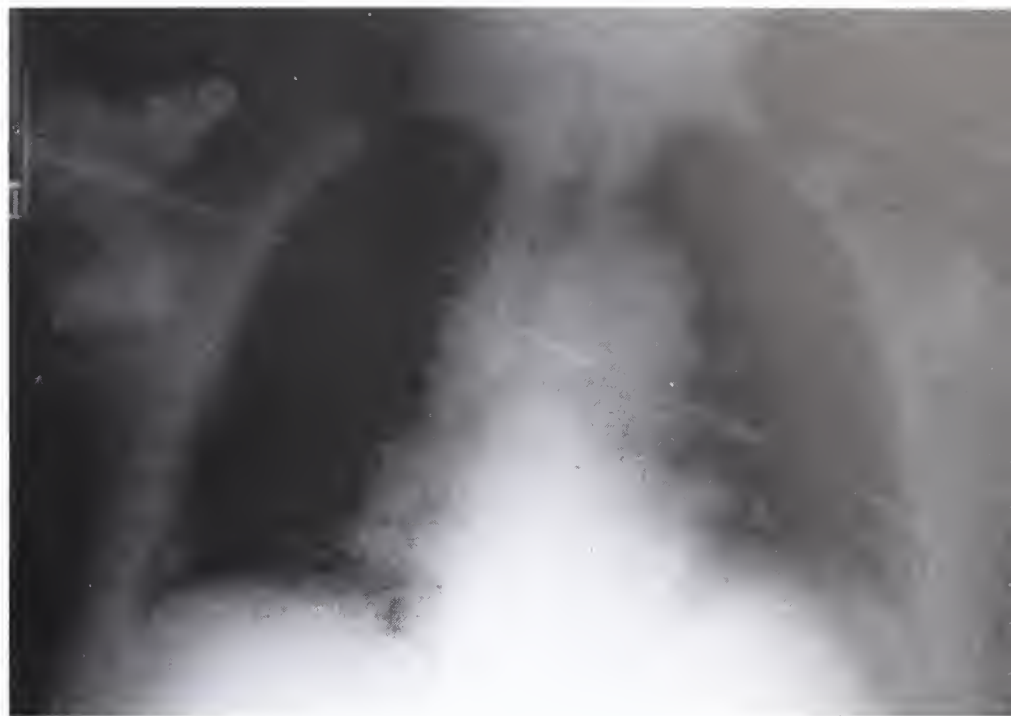
tremities. Deep tendon reflexes were normal. Vibratory sense and perception of fine touch were normal. Vibratory sense and perception of fine touch were normal. The patient experienced discomfort when his neck and joints were manipulated. The remainder of the physical examination was unremarkable.

Admission EKG was normal. The PA and lateral chest radiographs showed a suggestion of hilar fullness but no active disease was identified. The total white blood cell count was 11,400/mm<sup>3</sup> and contained 86% granulocytes, 5% band cells, 5% lymphocytes, and 4% monocytes. Serum chemistries measured his sodium at 129 mmol/L, BUN at 21 mg/dL, and creatinine 1.6 mg/dL. His total bilirubin was increased to 3.2 mg/dL, with 1.8 mg/dL reported as conjugated. His LDH was 1181 IU/L, AST 178 mg/dL, and ALT was 122 mg/dL. Erythrocyte sedimentation rate by the Westergen method was 42 mm/hr. Urine contained 100 mg/dL of protein, large amount of bilirubin, rare red blood cells, rare white blood cells, and 1+ bacteria. Initial bacterial cultures were negative.

No parasites were seen on a Giemsa stain of the peripheral blood. The CSF was clear and contained 9 white blood cells (all lymphocytes) per cubic millimeter. The protein content of the CSF was 54 mg/dL and the glucose was 85 mg/dL. Microscopic examination of the CSF was unremarkable. CSF was sent for culture and counter immune electrophoresis (CIE). Blood and urine cultures were obtained. Serologies were ordered for antibodies to *Rickettsia*, *Legionella*, *Brucella*, *Borrelia*, *Typhus*, and *Leptospira*.

The initial provisional diagnosis was felt to be most consistent with a vector borne (tick) illness and doxycycline was begun. Because of the degree of muscle weakness and the consideration of a possible ascending radiculopathy/myopathy, the patient's vital capacity (FVC) and negative inspiratory force (NIF) were recorded daily. The initial FVC was 2.8 L/min with a NIF of 70 cm H<sub>2</sub>O. On the second hospital day, the FVC had fallen to 1.8 L/min and the NIF declined to 60 cm H<sub>2</sub>O. A chest film obtained on the second day showed poor inspiratory effort with areas of bilateral congestion and a small left pleural effusion (Figure). The patient continued to have fever elevations to 104.4°F.

At 72 hours, his FVC had decreased to 1.2 L/min with a NIF of 40 cm H<sub>2</sub>O. Shallow respirations with a respiratory rate of 34/min were observed. Adventitious sounds were heard through-



out both lung fields. A new petechial rash was now discovered over the pretibial aspects of the lower extremities. Muscle strength in his extremities worsened to one fifth in the lower extremities and three fifths in the upper extremities. His condition deteriorated rapidly. He became extremely tachypneic and was electively intubated and mechanically ventilated. Antibiotic coverage was changed to chloramphenicol and penicillin. An echocardiogram showed normal valvular and ventricular function.

Subsequently, his bilirubin peaked at 8.2 mg/dL (direct fraction 7.2 mg/dL). Examination of the bone marrow, skin biopsies, and repeat examination of the CSF failed to identify a pathogen. Renal function remained normal. Dark phase microscopy of the urine identified spirochetes and they were also recovered from blood cultures. After 6 days, the patient was removed from mechanical ventilation. Gradual but steady improvement in his respiratory parameters and muscle strength was observed. He was discharged with a normal chest radiograph and a FVC of 3.3 L.

## Discussion

In the United States, a wide variety of wild and domestic animals harbor *Leptospira*. Infectivity rates of 10% to 50% have been reported in rats,



## Respiratory Complications of Leptospirosis

opossums, and raccoons. Humans develop leptospirosis after coming into contact with the urine or tissues of infected animals. Portals of entry for the spirochete include direct contact with abraded skin or mucous membranes and ingestion of contaminated water or vegetation. Once considered an occupational zoonosis, less than 20% of the patients in the United States who develop this disease have direct contact with infected animals.<sup>8</sup> Most individuals, such as our patient, have an incidental exposure to contaminated water.

Leptospirosis is uncommon in the United States with only 50 to 150 cases reported annually.<sup>8</sup> This disease is more common in tropical and subtropical climates, particularly in the Far East, where heavy rains lead to wide propagation of *Leptospira* that can affect harvest workers with skin abrasions.<sup>9</sup>

In order to determine the incidence and significance of the symptoms and signs of human leptospirosis, we must look to the large case reports from those countries with the most disease. In doing so, we must acknowledge several limitations. Most authorities feel that leptospirosis has a natural difference in virulence in different parts of the world. This might be attributed to a true difference in the disease caused by different species of *Leptospira* or to individual differences in host immune response as a result of comorbid disease or nutritional status. Likewise, there may be an unintentional bias in selection of patients as a result of limited health care resources. Direct extrapolation of data from these studies, while necessary, is also dangerous.

Leptospirosis is often a biphasic illness. The first phase is heralded by an abrupt onset of fever, chills, headache, and myalgia that persist for 4 to 9 days. These initial symptoms are attributed to toxins released by the spirochetes. Treatment instituted during the initial phase with doxycycline or penicillin is effective in shortening the course of the illness.<sup>10,11</sup> The second phase begins after a short asymptomatic period of 2 to 3 days and is attributed to the body's immunologic response to the spirochete. Serologic tests for *Leptospira* become positive during this interval. Complete recovery after acute illness is expected, but mortality rates ranging from 2% to 14% have been reported.<sup>14</sup>

Minor pulmonary involvement in leptospirosis is well recognized and has been confirmed by monitoring chest radiographic findings. Small nodular densities, confluent areas of consolidation, or diffuse ground glass densities are found

in 23% to 64% of patients with acute disease.<sup>12, 13</sup> Serial films show a tendency for the nodular pattern to progress to the confluent consolidation and/or the ground glass density. In the majority of patients, the radiographic abnormalities appear between the 3rd and 7th day after the onset of clinical symptoms. The lesions are usually bilateral and have a peripheral predominance. Complete resolution of radiographic abnormalities is usually seen.

Pleural effusion is expected in 9% to 12% of patients. These fluid collections have generally been small and unilateral. None of the patients with pleural effusion described in the literature have undergone thoracentesis and the exact nature of the fluid is not known.

There is little argument regarding the etiology of the early radiographic abnormalities described above. Densities seen on chest radiographs obtained immediately before death in some patients were correlated with autopsy findings of alveolar hemorrhage and consolidation.<sup>14</sup> Despite this observation, there is a lack of consensus regarding the prognostic significance of the presence of radiographic abnormalities. Wang et al<sup>15</sup> felt that the extent of radiographic abnormalities were proportional to the clinical severity of the disease in patients reported from China. Lee et al<sup>13</sup> found radiographic lesions to be nonspecific and to occur extensively in the absence of clinical signs and symptoms. More recently, Park et al<sup>9</sup> noted that all of their fatal cases had roentgenographic chest lesions and profuse massive hemoptysis before death. The mortality rate of 5% in their series was related by the authors to the severity of the radiographic lesions and massive hemoptysis rather than the severity of jaundice or the severity of renal failure. Interestingly, 27% of all patients with hemoptysis in the same report had normal chest radiographs. Likewise, chest auscultation was noted to be less abnormal than expected from the radiographic studies. At this juncture, the only reliable statement that can be made is that patients with extensive pulmonary radiographic abnormalities have a slower recovery than those without radiographic lesions.<sup>13</sup>

As suggested by autopsy and radiograph correlation, the primary pulmonary involvement in leptospirosis is a hemorrhagic pneumonitis and is usually considered incidental.<sup>16</sup> However, reports from some Far East countries suggest that many patients present with frank pulmonary hemorrhage.<sup>9, 12</sup> Such hemoptysis is a reflection of significant alveolar hemorrhage and has been reported in 3% to 40% of patients. These patients

are generally free of cardiac failure or myocarditis.

Hemoptysis has been noted most frequently in the septicemic phase of the illness. Until recently, recovery of leptospires from lung tissue has been extremely rare.<sup>1-8</sup> However, in the fatal cases of alveolar hemorrhage reported from Korea,<sup>9</sup> large numbers of *Leptospira* were found at autopsy in the lung tissue. Recovery of spirochetes suggests that capillary damage may be effected by the direct action of a leptospiral toxin in some cases.<sup>17</sup>

The pathophysiology of ARDS in leptospirosis is unclear, and has been attributed to the effect of toxins or immune complexes on the alveolar-capillary membrane. In the animal model, vascular endothelial damage can be seen.<sup>18</sup> Desquamation of capillary endothelial cells with the presence of leukocyte and platelet thrombi is consistent with the histology described in the adult respiratory distress syndrome. Postmortem examination of some patients with fatal leptospirosis and clinical ARDS has confirmed the presence of pulmonary edema, intra-alveolar fibrin, cellular infiltration, alveolar necrosis with fibroblastic reaction, and hyaline membranes.<sup>9, 14</sup>

Our patient had pulmonary densities and a small left pleural effusion on his chest radiographs which would suggest the presence of hemorrhagic pneumonitis. Hemoptysis did not occur. He had significant weakness of his extremities on admission which continued to deteriorate over a 96-hour period. He was intubated and placed on mechanical ventilation as objective measurements of his vital capacity and negative inspiratory pressure progressively worsened. Severe weakness was recorded in 62% of the patients with leptospirosis in Chonbuk Province of Korea.<sup>9</sup> The muscle biopsies performed on these patients showed interstitial hemorrhage and inflammatory cell infiltration. The clinical deterioration of respiratory function in our patient is analogous to that seen in some neuromuscular disorders and identifies yet another potential mechanism of respiratory impairment in leptospirosis, ie, ventilatory (bellows) failure.

In summary, leptospirosis is an uncommon disease in the United States. When it does occur, radiographic evidence of pulmonary involvement is frequent. Although the lesions are indicative of hemorrhagic pneumonitis, the majority of patients fully recover with only conservative supportive care. The potential for severe pulmonary morbidity is classically assigned to asphyxia sec-

ondary to massive hemoptysis and/or ARDS which are presumably mediated by leptospiral toxin or immune complexes. An additional mechanism for respiratory failure has been identified which is a severe and progressive weakness of the thoracic muscles from intramuscular hemorrhage.

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# A Unique Inlet [The Ascending Aorta] for Extra-Anatomic Bypass of Infected Arterial Prostheses

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## Introduction

Sepsis in reconstructive vascular surgery is rare. Its management is tedious, demanding and complex. We have reviewed our case histories over the past decade to delineate some of the most challenging. The purpose of this report is to: (1) record one such instance of prosthetic arterial sepsis requiring multiple admissions and procedures, with a fatal outcome; (2) review the cumulative experience of others; (3) reconsider the established concepts and principals of management; (4) enumerate and add to the technical methods of extra-anatomic bypass; and (5) reemphasize the associated morbidity and mortality. The case history extends over nearly 7 years; involves eight hospital admissions and seven major vascular procedures.

## Case History

A 71-year-old male with a history of coronary artery occlusive disease, prior inferior wall myocardial infarction, diabetes mellitus and hypertension was admitted for evaluation of severe peripheral vascular disease. Angiography revealed high grade, bilateral common and external iliac stenoses and an abdominal aortic aneurysm. The aneurysm was resected and arterial continuity restored with a 20 × 10 knitted bifurcation graft inserted in aorto-bi-femoral fashion. The patient received cephalosporin IV pre and postoperatively for 24 hours and Keflex p.o. postoperatively for 3 days, made an uneventful recovery, and was discharged 10 days later.

One year later, he developed cellulitis of both femoral incisions, was treated with oral antibiotics and the cellulitis subsided. One year later the cellulitis of both groin incisions recurred. He was

readmitted, at which time cultures were taken. *Corynebacterium* species and *Staphylococcus* species were cultured from the left groin; *Staphylococcus*, *Corynebacterium* and *Streptococcus viridans* were cultured from the right groin. He was treated with intravenous antibiotics for 10 days and discharged.

The following year, he complained of chills and fever, was seen in the emergency room and admitted. An abdominal CT scan revealed a gas-containing purulent collection around the aorto-bi-femoral graft. At operation, the entire bifurcation graft was removed. The abdominal aorta was closed with 3.0 prolene sutures and teflon pledgets just distal to the renal arteries and a vascularized pedicle of omentum was placed over the closure. The retroperitoneum was irrigated with bacitracin. Both groin incisions were debrided, irrigated with the same solution and closed. An extra-anatomic bypass graft from the left axillary artery to the left femoral artery, distal to the previous infected anastomotic site, was performed along with a left femoral to right femoral bypass graft. The patient received a 2-week course of intravenous Gentamycin and Mefoxin. Recovery was uneventful and he was discharged to receive oral Keflex, indefinitely.

Approximately 36 months later, the patient was readmitted with a chronically exposed infection of the left axillo-femoral graft in the mid-lateral thoracic area and infection in the left groin. The left axillo-femoral graft was removed and a right axillo-femoral extra-anatomic graft subsequently inserted. He again received intravenous antibiotics and was to continue oral Keflex indefinitely.

One month later, the patient was readmitted with bleeding from the right groin. The left groin

incision was locally debrided, irrigated with antibiotics and closed. A new segment of graft was inserted between the right axillo-femoral and the femoral-femoral cross-over graft. No more bleeding occurred. The following month, he was readmitted with bleeding from a sinus tract in the left groin, which subsided with local therapy and oral antibiotics.

The following month, he was readmitted for infection of the right axillo-femoral graft. There was residual drainage along the left lateral mid-chest at the previous left axillo-femoral graft site. Because of infection along the right axillo-femoral graft tract and drainage from the previous left axillo-femoral graft site, a median sternotomy was performed and an ascending aortic (retrosternal and retroperitoneal) to right groin bypass graft was inserted. This unique procedure was successful in revascularizing both lower extremities for nearly a year.

His final admission was for anemia and progressive renal failure. The BUN and creatinine increased to 84 and 4.0, respectively; he developed pneumonia and expired 1 month later.

## Discussion

The manifestations of infected arterial prostheses are (1) pseudoaneurysm; (2) hemorrhage; (3) thrombosis of the prosthesis; (4) abscess; (5) chronic draining sinus; (6) septic emboli; (7) propagation of infection [along the graft/to contralateral limbs of bifurcation grafts]; (8) septicemia; and (9) metastatic abscess.

## Generalizations

The original generalizations of Shaw and Baue<sup>1</sup> concerning the behavior of infected arterial reconstructions remain relevant. These are:

1. Infected suture lines involving an unthrombosed artery almost invariably give way and bleed massively. Operation consisting of removal of all graft material, suture of viable arterial wall to viable arterial wall, exclusion of the suture line from the main body of the wound by live tissue, and wide drainage of the wound may sometimes result in successful secondary healing without thrombosis.
2. Sepsis does not run up and down an unthrombosed arterial graft, but remains fairly local to its point of origin.
3. Sepsis propagates up and down a thrombosed graft. Such grafts must be removed in their

entirety, preferably before sepsis has propagated through the thrombus to a suture line and hemorrhage has occurred.

4. An exteriorized segment of prosthetic graft not involving a suture line can only rarely be encouraged to be reenclosed by secondary healing and usually remains chronically infected with episodes of minor bleeding and bacteremia. In instances where an abscess involves a deeply situated and well-covered segment of graft, incision and drainage, and a limited attempt for secondary healing are probably worthwhile. Flap closure does not tend to work well in superficial exteriorized graft segments. Such exteriorized graft segments may be the result of excessive graft length. When the graft threatens to exteriorize itself because of pressure necrosis caused by extra length and buckling rather than sepsis, it is very easily shortened and replaced in its bed, if the situation is recognized while the skin is still intact.
5. Sepsis involving retroperitoneal prosthetic grafts commonly becomes apparent months after grafting, may have ureteral stricture as an accompaniment, and ultimately leads to major hemorrhage from a suture line.
6. The ideal surgical treatment of a chronically infected arterial reconstruction involves:
  - a. Isolation and defunctioning of the infected segment by division of the uninfected artery or graft proximally and distally through clean incisions.
  - b. Exclusion of the ends of the defunctioned segment from these clean fields.
  - c. Restoration of vascular continuity by bypass grafting around the septic region.
  - d. Standard treatment of the infected segment by drainage, removal of foreign body, etc, after the clean incisions have been closed and protected.

The alternative routes to circumvent sepsis are:

1. High aorto-femoral between descending thoracic aorta and femoral artery (lateral retroperitoneal placement).<sup>2</sup>
2. High aorto-femoral between infra-diaphragmatic aorta and femoral artery (anterior extraperitoneal placement).<sup>2</sup>
3. Axillary-femoral bypass with subcutaneous placement of the graft.<sup>3</sup>
4. Cross-leg iliofemoral bypass with extraperitoneal and subcutaneous placement.<sup>4</sup>
5. Cross-leg femoral-femoral with subcutaneous placement of the graft.<sup>4</sup>
6. Lateral ilio-femoral bypass with retroper-



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itoneal placement.<sup>5</sup>

7. Trans-obturator ilio-femoral bypass via the obturator foramen.<sup>1</sup>
8. Ascending aorta and femoral artery (retro-sternal and retroperitoneal [this report]).

In a series of 890 patients, Fry and Lindenauer<sup>6</sup> found that infection of arterial prostheses occurred in 12 instances, an incidence of 1.34%. In their experience this complication was associated with a 75% mortality. The common mode of onset was thrombosis of one, or both limbs of a graft. The cause of death most often was hemorrhage. The organism responsible in the majority of incidences was *Staphylococcus*. Complete removal of the infected prostheses and secondary bypass through an uninfected area was the recommended method of management.

Szilagyi, over a prolonged period of observation, found an incidence of infection of 0.7% in aorto-iliac, 1.6% in aorto-femoral, and 2.5% in femoro-popliteal operations. The single most common source of infection was the inguinal skin; the second was perforation (erosion) of a hollow viscus. With the use of prophylactic antibiotics, the overall incidence of prosthetic graft infections was reduced from 4.1% to 1.5%.<sup>7</sup>

### Summary

Infection is the most dreaded complication associated with implantation of a prosthetic arterial graft. The reported incidence of primary graft infection varies from 1.3% to 6.0%, with a mortality rate from this complication as high as 75%.<sup>6-14</sup> Although remote bypass followed by complete removal of the infected prosthesis has proven to be a satisfactory method of treatment,<sup>15</sup> in certain instances remote bypass alone is not feasible and other modes of surgical treatment must be employed.<sup>16</sup> Such conservative methods of management of infected aorto-iliac-femoral prostheses sometimes irradiate infection. The only certain cure, however, is obtained by totally removing the graft. And the success of extra-anatomic axillo-femoral techniques has led to its extended use. The addition of a cross-limb on an axillo-unilateral femoral graft to form an axilobilateral femoral graft was described by Sauvage and Wood,<sup>17</sup> reasoning that the higher flow rate in the axillary limb of the axilobilateral femoral graft would result in an improved patency rate compared with

that of axillounilateral femoral grafts. Additionally, both medial (obturator foramen) and lateral extra-anatomic remote bypass of infected femoral prostheses have been used, successfully.

The current case illustrates the complexity of management, once sepsis occurs. It further focuses on groin, retroperitoneal and bilateral axillo-femoral tract infection with prolonged (apparently innocuous) graft exposure and finally points out the utility of the ascending aorta as an alternative extra-anatomic inlet to perfuse the lower extremities.

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# Thallium Redistribution Does Not Predict Perioperative Cardiac Complications Following Vascular Surgery

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*Utility of preoperative stress thallium scintigraphy (STS) was determined in 59 patients, thought to be at increased risk, prior to major vascular surgery from July 1987 to February 1990. Forty-seven had oral dipyridamole and 12 underwent exercise STS. Thallium redistribution (TR) was present in 61% (n=36); fixed defects were present in 59% (n=35); and some combination of defects was present in 76% (n=45). Perioperative cardiac complications (CC = congestive heart failure [n=3], ventricular arrhythmia [n=2], and MI [n=1]) were present in 8.5% (6 CC in 5 patients). Incidence of CC was 8.3% (3/36) in those with TR, and 8.7% (2/23) without TR (relative risk = 0.95). Perioperative MI was present in 2.8% (1/36) with TR vs. 0% (0/23) without. Though mortality was 3.4%, no perioperative deaths were from cardiac disease. Utility of STS is not clearly established for prediction of perioperative cardiac risk after major vascular surgery.*

This study was done to further assess the utility of preoperative thallium scintigraphy, as it has been performed in most centers without an IND for intravenous dipyridamole, for prediction of risk of cardiac complications and death after major vascular surgery.

## Patients and Methods

From 7/87 through 2/90, 61 patients underwent stress thallium-201 (TI-201) scintigraphy (STS) at the University of Kentucky Hospital (UKH) and affiliated Veterans Administration Medical Center (VAMC) before major vascular surgery. This retrospective study evaluated outcome for a selected population: each patient undergoing STS did so because either the surgeons or cardiology consultants recommended the thallium study. STS was not done routinely: during the study 676 major vascular procedures were performed, so less than 10% of such procedures were preceded by STS. Patients undergoing STS before thoracoabdominal aneurysm repair (n=1) or hemodialysis access surgery (n=1) were excluded since these procedures represent extremes of surgical risk. Of the 59 remaining study patients, 47 underwent oral dipyridamole-thallium stress and 12 underwent exercise stress testing. Thirty-six of the 59 subjects had extremity reconstruction, including aortofemoral and more distal bypass; 12 had abdominal aortic aneurysm repair and/or renal revascularization; and 11 underwent carotid surgery.

STS was performed using single photon

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*Sponsored in part by American Heart Association, Kentucky Affiliate, and the University of Kentucky College of Medicine.*



## Introduction

Myocardial ischemia is the most common cause of perioperative and late death in patients with peripheral vascular disease.<sup>1</sup> Preoperative evaluation, however, cannot accurately predict risk for an individual undergoing major vascular surgery. Though studies have assessed thallium scintigraphy for prediction of perioperative cardiac complications, prediction of cardiac death after vascular surgery remains an unsolved problem, and intravenous dipyridamole has remained unavailable until very recently.<sup>2-15</sup>



## Thallium Redistribution

emission computed tomography (SPECT) at UKH and using planar imaging at the VAMC. Dipyridamole was administered orally in a 300-375 mg dose in this subgroup. Forty-five minutes after oral dipyridamole administration, 4 millicuries of thallium were injected intravenously. Blood pressure, ECG, and clinical response were monitored by a physician. Intravenous aminophylline was administered if nausea, vomiting, or chest pain followed dipyridamole administration. Thallium myocardial perfusion images were obtained 5 to 10 minutes after Tl-201 injection. Exercise STS was performed using the Bruce protocol ( $n=11$ ) or arm ergometry ( $n=1$ ). Stress exercise images were obtained immediately after maximum exercise. Delayed images were obtained 3 to 4 hours after the stress images. Six of the 12 undergoing exercise STS reached or exceeded 85% of the age-adjusted maximal heart rate. In the subgroup undergoing exercise STS each patient either had thallium redistribution or achieved the target heart rate.

Stress and resting Tl-201 images were interpreted by physicians experienced with these tech-

niques. The presence of one area or more of thallium redistribution (TR) was defined as abnormal. Areas with a sustained lack of perfusion on delayed images were defined as fixed defects. Defects were classified as periinfarct redistribution (Tl-201 redistribution adjacent to a fixed defect) or "other" areas of redistribution (TR not adjacent to a fixed defect). The number of areas of TR was quantitated.

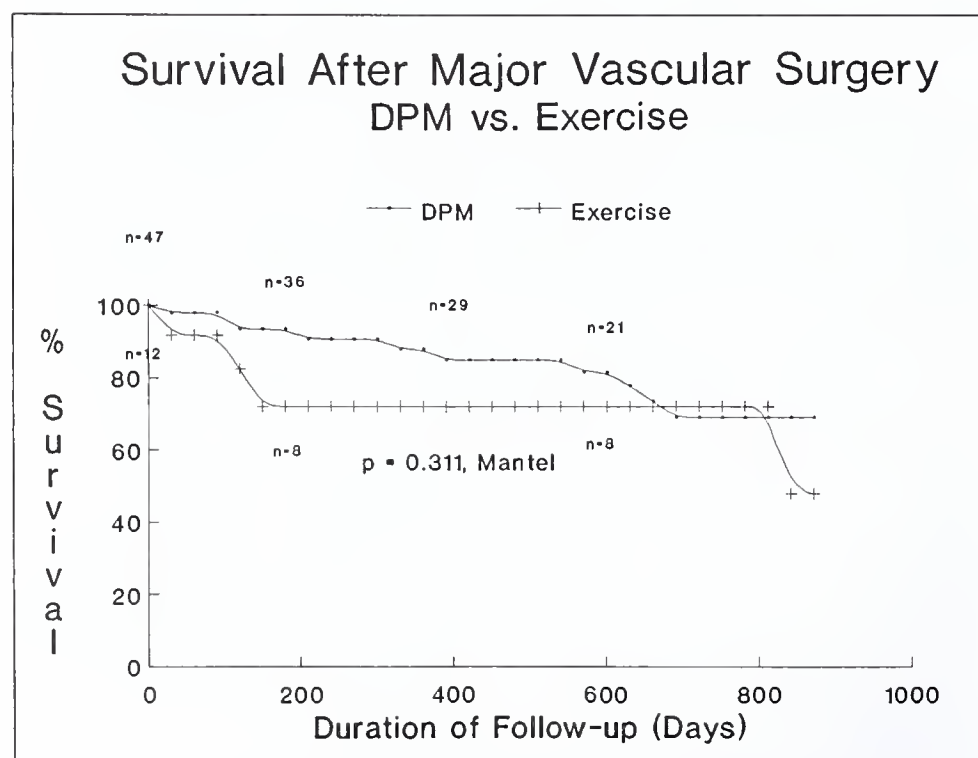
Perioperative (within 30 days of surgery) deaths and cardiac complications (CC) were determined. CC included: (1) Myocardial infarction diagnosed by elevated creatine kinase isoenzymes, ECG, and clinical course; (2) Ventricular arrhythmia requiring treatment; and (3) Congestive heart failure defined as that requiring specific therapy and prolonging stay in or resulting in admission to an intensive care unit. Patients were followed to assess perioperative complications and overall survival. Statistical analysis was done using Systat software.

## Results

The age of the 59 study patients was  $64 \pm 11$  years (mean  $\pm 1$  s.d.), range 36-86 years. Risk factors were typical: 73% ( $n=43$ ) were hypertensive, 42% ( $n=25$ ) were diabetic, and 85% ( $n=50$ ) were cigarette smokers. A history of myocardial infarction (MI) was present in 44% ( $n=26$ ), and ECG evidence of prior MI was present in 37% ( $n=22$ ), while 32% ( $n=19$ ) had angina. Prior coronary bypass or angioplasty was done in 19% ( $n=11$ ).

Thallium redistribution was present in 61% ( $n=36$ ) of patients. TR involved an area adjacent to a fixed thallium defect in 41% ( $n=24$ ) of the group, while 36% ( $n=21$ ) had other redistribution patterns. Fixed thallium defects were present in 59% ( $n=35$ ). A total of 76% ( $n=45$ ) had an abnormal study with either TR or fixed defect. The incidence of such abnormalities and the outcome were not statistically different for those having planar versus those having SPECT studies.

Postoperative complications included myocardial infarction in 1.9% ( $n=1$ ), new ventricular arrhythmia in 3.8% ( $n=2$ ), and congestive heart failure in 5.8% ( $n=3$ ). The incidence of cardiac complications was 8.5% (six CC in five patients). When the endpoint was defined to be detection of perioperative cardiac complications, TR was 60% sensitive and 39% specific. The incidence of perioperative cardiac complications was 8.3% (3/36) in those with thallium redistri-



**Fig 1 — Lifetable analysis of survival after major vascular surgery for those undergoing DPM Tl-201 ( $n=47$ ) vs exercise ( $n=12$ ) stress thallium scintigraphy. There was no significant difference in overall survival ( $p=0.311$ , Mantel-Haenszel).**

bution and 8.7% (2/23) in those without TR (relative risk = 0.95).

Perioperative mortality was 3.4% (n = 2), and no deaths were due to cardiac disease. One death was due to intraoperative hemorrhage, and the other was due to rupture of an abdominal aortic aneurysm following discharge 26 days after carotid endarterectomy. The latter patient consented to carotid surgery but refused aneurysm repair and returned to the hospital moribund. Thallium redistribution was not statistically related to the cardiac complication rate (Fisher exact,  $p = 0.637$ ) and/or perioperative mortality for the entire group or for the subgroup undergoing oral-dipyridamole TI-201 STS.

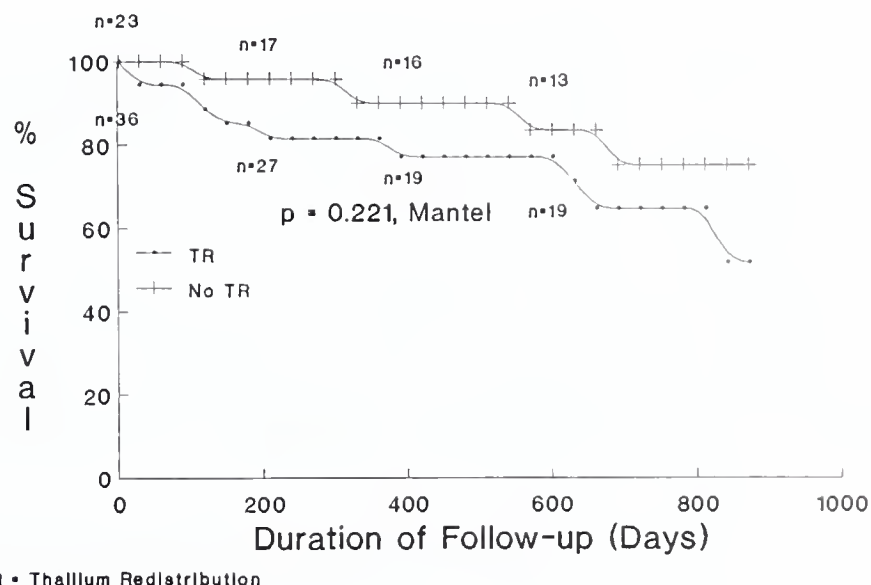
Cumulative mortality was 23.7% (n = 14) during follow-up of  $475 \pm 294$  days. There was no statistical difference in survival for those undergoing exercise vs dipyridamole STS (Fig 1). In the whole group of 59 or in the subgroup of 47 who underwent dipyridamole STS there was no statistical association with thallium redistribution and survival after surgery (Figs 2 and 3). There was no detectable association between periinfarct TR, "other" TR, the number of areas of TR, fixed defects, or abnormal STS and perioperative cardiac complications or overall survival.

## Discussion

Any method of preoperative cardiac assessment is likely to detect coronary disease in vascular patients: 4% to 5% of patients undergoing vascular surgery have left main and 17% to 21% have triple vessel coronary artery disease, while only 8% have angiographically normal coronaries.<sup>1</sup> The incidence of coronary disease is similar for all primary peripheral vascular diagnoses, whether patients present with aneurysms, carotid disease, or extremity occlusive disease.<sup>1</sup> Detection of coronary disease should not be the endpoint of preoperative testing, since it is safe to assume that it is present in those who need vascular surgery. It would be more important to detect coronary disease that might result in perioperative complications or death.

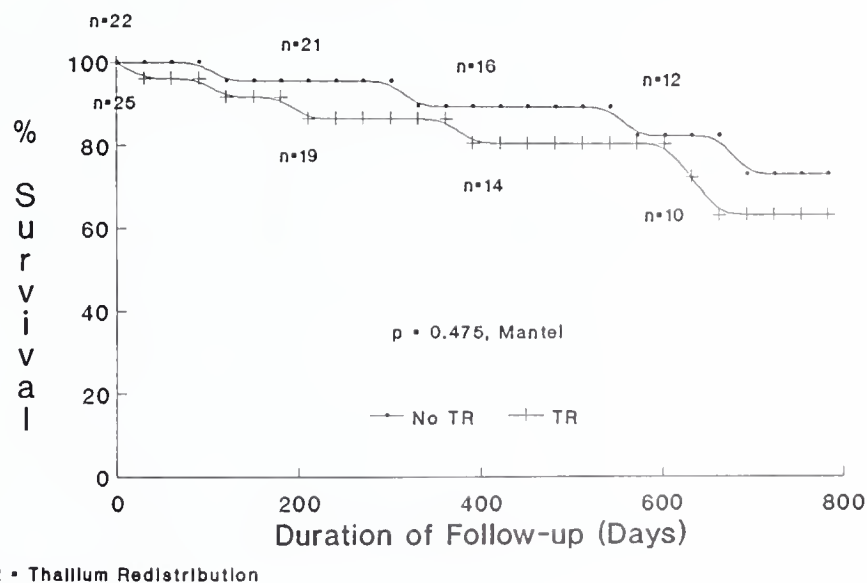
The most suitable method for defining perioperative cardiac risk for vascular patients remains elusive, however. Routine preoperative coronary angiography has not reduced overall risk for patients who present with peripheral vascular disease in need of surgical treatment.<sup>1</sup> Information gained from routine coronary arteriography cannot be translated into a clinical approach

## Survival After Major Vascular Surgery Thallium Redistribution



**Fig 2 — Lifetable analysis of survival after major vascular surgery for the whole group undergoing stress thallium scintigraphy (n = 59). There was no statistical difference in survival in those with (n = 36) vs those without (n = 23) thallium redistribution ( $p = 0.221$ , Mantel-Haenszel).**

## Survival After Vascular Surgery Dipyridamole TI-201 (n = 47)



**Fig 3 — Lifetable analysis similar to Figure 2 but limited to those undergoing dipyridamole thallium scintigraphy (n = 47) before major vascular surgery. There was no statistically significant survival difference between those with (n = 25) vs those without (n = 22) thallium redistribution in this subgroup.**



## Thallium Redistribution

**Table I. Mortality After Vascular Surgery With Thallium Redistribution (TR)**

	Periop Deaths	Number with TR
Boucher, et al	1	16
Cutler and Leppo	0	39
Eagle, et al	5	42
Fletcher, et al	1	3
Sachs, et al	2	14
Kazmers, et al	2	36
	11	150
Perioperative Mortality (11/150) = 7.3%		

which has been clearly proven to reduce overall mortality for such peripheral vascular patients. The risk of cardiac complications after noncardiac surgery attributable to a given coronary artery disease pattern has not been adequately established.

Standard exercise treadmill testing, thought to be of diminished value for vascular patients, is useful when patients achieve 85% or more of their age related maximum heart rate or when they exhibit myocardial ischemia (have a positive test) even at submaximal exercise.<sup>16</sup> Due to difficulty with exercise testing, alternative methods were developed to mimic the cardiovascular effects of exercise. Although the hemodynamic effects of exercise and dipyridamole differ, dipyridamole has been used as a pharmacologic substitute for exercise in conjunction with thallium scintigraphy.<sup>17</sup> Studies suggest vascular patients with thallium redistribution found during intravenous dipyridamole Tl-201 scintigraphy are at increased risk for perioperative cardiac complications.<sup>2-4</sup> Unfortunately, intravenous dipyridamole has remained unavailable except as an investigational drug until very recently. Despite this, use of intravenous dipyridamole for STS has seemingly become the gold standard for noninvasive cardiac assessment before vascular surgery, even though there is a lack of widespread experience with this technique. Centers such as our own have substituted oral dipyridamole for intravenous in testing selected patients, but this agent administered orally may be less sensitive for detection of coronary disease.<sup>18</sup> Both oral and intravenous dipyridamole thallium studies, however, are too sensitive for use in detecting perioperative cardiac complications in vascular patients since, although patients often have thallium redistribution, most will not have postoperative cardiac

complications. Such dipyridamole Tl-201 scans also do not define the risk of cardiac death after vascular surgery.<sup>2-3, 6-7, 12-15, 19, 20</sup> For example, Cutler and Leppo found an increased risk of perioperative myocardial infarction after vascular surgery, but perioperative mortality in those with thallium redistribution was low ( $2/54 = 3.7\%$ ) and was limited to patients having coronary bypass — one death was due to aortic aneurysm rupture and the other to complications after CABG.<sup>3</sup> None with thallium redistribution in the latter series died from cardiac causes after vascular surgery.<sup>3</sup> A gross estimate of the perioperative mortality for those undergoing vascular surgery without prior myocardial revascularization despite preoperative evidence of thallium redistribution is 7.9% (9/114) based on a review of other studies which include sufficient information to make such a determination.<sup>2, 3, 6, 12, 14</sup> If results of this study are included (2 deaths/36 patients with redistribution) the perioperative mortality rate is 7.3% if the noncardiac deaths are included (Table I) and 6% if they are not included.

Vascular surgeons have been bridled with the expectation that intravenous dipyridamole STS be done as the best preoperative test to assess cardiac risk, though it may not predict perioperative cardiac complications or mortality with accuracy and has been unavailable at most centers. Oral dipyridamole-thallium scintigraphy has been substituted, but our results suggest that neither oral nor exercise DPM STS defines those at increased risk of cardiac complications or death. The only patients who died in our study experienced exsanguinating hemorrhage, one from coagulopathy and one from ruptured aneurysm. Both patients had thallium redistribution, but the deaths were noncardiac in nature. The incidence of cardiac complications in those with redistribution in our series was similar to that without redistribution (8.3% and 8.7%, respectively). Though not a universal experience, it has been suggested those with no thallium redistribution are at low risk and require no further preoperative cardiac workup.<sup>19</sup> Some have suggested fixed defects are not associated with increased risk.<sup>3, 13</sup> In this study those with fixed defects only (no evidence of thallium redistribution) had a 22% (2/9) cardiac complication rate. It is possible that some fixed defects might represent a more delayed redistribution than is detected by standard testing.<sup>20, 21</sup>

It is unclear who should have a thallium scan before vascular surgery. Intravenous dipyridamole thallium STS is not innocuous.<sup>22</sup> It also re-

mains unclear how to proceed with patients who have thallium redistribution or fixed defects. Our studies show those with periinfarct or other redistribution are not statistically at greater risk of perioperative cardiac complications. Coronary arteriography for all patients with thallium redistribution who need vascular surgery is probably not warranted due to the frequency of false positive and negative thallium studies. Limiting invasive evaluation to those with redistribution would not be helpful since those without redistribution may have equivalent perioperative cardiac risk. The significance of fixed thallium defects also remains controversial.

Until such controversies are resolved, when confronted with a patient thought to be at increased risk based on thallium STS, one can: (1) utilize other noninvasive methods of preoperative cardiac assessment such as radionuclide ventriculography to further define risk;<sup>23-24</sup> (2) intensify treatment of underlying coronary disease (either medically or by coronary bypass or angioplasty); (3) optimize the patient's general medical condition; (4) minimize or avoid the surgical procedure when feasible (ie perform balloon angioplasty instead of surgery or use extraanatomic bypass when appropriate); (5) operate only for compelling life- or limb-threatening problems; (6) minimize anesthetic risks (ie use local anesthesia or alter anesthetic technique); (7) utilize invasive hemodynamic monitoring during the perioperative period to detect and minimize hemodynamic changes; and (8) aggressively treat intra- and postoperative arrhythmias, myocardial ischemia, and blood pressure alterations pharmacologically.<sup>25</sup> The approach to each patient would need to be individualized.

## Conclusions

A critical review of the literature and the results of this study suggest that dipyridamole Tl-201 scanning for prediction of perioperative cardiac complications or death requires further scrutiny. In this study the only perioperative deaths were noncardiac in nature, and thallium scanning is not likely to predict such deaths. Unfortunately, others have not shown thallium STS to accurately predict perioperative cardiac death following vascular surgery.<sup>2, 3, 6, 12, 14, 20</sup> Such negative reports as this one, though unwelcome, represent clinical reality. Unless such reports are added to the literature, the accuracy of preoperative thallium testing will retain an inflated value.<sup>26</sup> Perhaps fu-

ture improvements in the technique of thallium scintigraphy, along with widespread clinical availability of intravenous dipyridamole, will provide more useful information for determining cardiac risk in those who need major vascular surgery.

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## Quiz on Costs of Medical Care

**T**O THE EDITOR: The following is a quiz on *Costs of Medical Care*, previously published in the JCMS bulletin. The quiz was designed to promote cost awareness among physicians. The quiz received many positive responses from Louisville physicians, several of whom suggested it would be appropriate to reprint in the KMA journal to give it somewhat wider circulation in Kentucky.

We hope you enjoy testing your cost consciousness.

	YES	NO
1. I use outpatient or extendacare facilities for invasive diagnostic procedures (myelograms, arteriograms, endoscopy) and minor surgical procedures whenever possible.	_____	_____
2. I consider the price as well as the quality of care when choosing a hospital for admission of a patient or obtaining outpatient diagnostic exams. (for profit hospitals average 20-24% higher costs nationally)	_____	_____
3. I use generic drugs whenever possible.	_____	_____
4. I consult the hospital based physicians for advice about the relative costs of diagnostic tests whenever there is more than one test which can examine a body organ or fluid.	_____	_____
5. I consult the hospital pharmacist regarding the relative costs of drugs, for example antibiotics or intravenous fluids, and include cost in choosing which drug to use.	_____	_____
6. I consider cost, as well as quality, even though my patients have insurance, when choosing a consultant to provide care for my patients.	_____	_____
7. I would use lists of prices of drugs, diagnostic exams, and therapy (such as blood products) in determining patient care if it were provided to me by the hospital.	_____	_____
8. I complete my charts including diagnosis as quickly as possible to facilitate hospital billing and prevent expensive duplication of services by the medical records department.	_____	_____
9. I realize that if every physician in the Jefferson County Medical Society reduced their patients hospital stay by one day millions of dollars in medical care costs could be saved annually.	_____	_____
10. I routinely use hospital protocols, and/or counsel patients, to minimize complications in high risk patients for falls, atelectasis/pneumonia, decubitus ulcers, or thrombophlebitis.	_____	_____
11. I routinely check records to see when patients have had prior x-rays or labs before ordering diagnostic exams to avoid unnecessary and duplicated services.	_____	_____
12. I encourage patients to maintain their own records of dates of previous diagnostic tests.	_____	_____
13. I avoid feeling as if I always have to give patients prescriptions by using patient education materials such as diet, exercises, body mechanics, or hygiene instructions.	_____	_____
14. I routinely practice preventive medicine by encouraging weight control, discussing tobacco and alcohol habits, or suggesting stress management for all my patients.	_____	_____

Scoring your answers:

Give 1 point for each yes answer, 0 for each no answer.

Score 12-14 — You are cost conscious! You are a part of the solution!

Score 8-11 — You are generally cost conscious. Keep working on it!

Score 4-7 — You need to pay more attention to keeping medical costs down.

Score 0-4 — You are part of the problem. We all need your help in controlling cost escalation.

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# Where Nobody Knows Your Name

Is it just me? Am I such a cipher? Do I tend to blend in with the wallpaper? I am referring to my fear and awkwardness when I have to visit a patient at a "foreign" hospital where my face and manner are not home grown.

There is a certain ease and familiarity with one's daily hospital where the repartee and interplay with the nurses is pleasant as well as professional. But I would sooner eat a salad of rhubarb and brussels sprouts in the midst of a mine field than to have to care for a patient that is off my own bailiwick.

First of all I have to locate the hospital in question. Well that's not too hard. Any Michelin guide book and Exxon map along with a neighborhood cop can usually help me find the place. Once there I hope and pray that my plastic card and/or circular metal key will activate the long yellow arm that forbids entrance into the hallowed doctor's parking lot. After several jabs with my card and many turns with my key, the yellow monster stays horizontally frozen like stale bread on the Russian steppe. I turn my car around and head for the more user-friendly visitor parking lot. The nearest vacant slot is a taxi ride away and the handicapped parking area certainly does look tempting; but I resist. So I pack a lunch and start the trek to the front door. Should I wire home and have them get the will out in case I don't return?

---

***“There is a certain ease and familiarity with one's daily hospital where the repartee and interplay with the nurses is pleasant as well as professional. But I would sooner eat a salad of rhubarb and brussels sprouts in the midst of a mine field than to have to care for a patient that is off my own bailiwick.”***

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Safe at last. I'm inside the door. Many friendly faces peer at me in wonderment. Am I an in-coming patient, a visitor, a doctor, a homeless person out of the cold? And my hat and coat . . . where do I put them? The doctor's lounge has got to be somewhere but behind what door. Do I have the card, the key, and the proper sequence of numbers to spring the lock to this "Fraternity Room"? Maybe, just maybe someone in there will know me. Then again maybe not. I graduated just a year ahead of Sir William Osler so I'm hardly a household word. Sort of like a Spiro Agnew.

Where-oh-where is radiology? Is the laboratory in the sub-basement behind the furnace just across from the laundry? Elevators? Are there elevators or do I have to pass a fitness test in the stairwell to qualify

to see this one patient here in the urban boondocks?

Finally I hit the proper floor and locate ICU behind sliding glass doors that carry a two-foot sign that reads "no admittance." My new svelte figure barely has enough weight to activate the treadle. I step in then the doors whoosh shut trying to pancake me into submission for being the unwelcome interloper I am.

"Hi," I say, "I'm Doctor Miller here to see Mrs Bedford in room 18."

The floor nurse, whose grandmother was probably married to Attila the Hun stares at me motionless like a panther in stalk of her prey. I freeze. I'm found out. I am a fraud. Maybe I'm here to see Mrs Room in bed 18, I don't know!

How to prove I am a doctor. I whip out my wallet for identification, but all I have in there is plastic money and a list of past derby winners. What to do? I hold up my medical bag, raise my eyebrows, and point to the bag and nod. The nurse rolls her eyes back and shakes her head, then gives me the chart. I'm in business.

The chart is heavy and thick, and has been thinned many times on this patient that was admitted to the hospital at the turn of the century. The aluminum springs barely have enough bite to get a strong purchase upon the many papers and the chart explodes like a grenade.

I hesitatingly ask for the vital



signs, the graphics, and current medication. A second chart is thrust in my hand. It is thin and neat. But the papers within unfold into a three-page monster of lines, squares, numbers, and abbreviations that resemble a print-out of a six-day Discovery space mission. I ask for the medicine chart and I am aimed down the hall to the nurse who has the medication cart. I walk down and sure enough there it is. I am privileged to try to read the faint third carbon copy written in ballpoint by a nurse who hasn't enough pressure to rupture the pulp out of a grape skin.

Finally I dialogue with the patient. But it isn't a dialogue, it is a monologue . . . mine. The patient is out of it and has more tubes in him

than a Delmonico macaroni factory. I quickly examine the patient and hurry back to the chart to make my entry and contribution which is rather profound and reads, "as above." I look above and see that the note written there is a scribble of Sanskrit that even the Hindus could not make out.

I cap my pen and close my bag to slink away from the station. The charge nurse now oozing with compassion and with all doubts gone calls after me to come back again soon. I tell her I shall, then murmur to myself, "When they serve brunch on the back side of the moon."

**Milton F. Miller, MD**

## JUNE

**12-15 — American Academy of Family Physicians, Kentucky Chapter, Annual Meeting,** Galt House, Louisville, KY. Contact: Gayle Knopp, 502/451-0370.

**13-14 — Cardiology in Practice,** Hyatt Hotel on Capitol Square, Columbus, OH. Contact: Ohio State University, 800/492-4445.

**13-15 — 36th Great Smoky Mountains Pediatric Seminar,** Park Vista Hotel, Gatlinburg, TN. Contact: The University of Tennessee Department of CME, 1924 Alcoa Hwy, D-116, Knoxville, TN 37920; 615/544-9190.

**17-21 — Thirteenth Family Medicine Review,** Hyatt Regency Hotel, Louisville, KY. Contact: Laura Tucker, CME, University of Louisville, Louisville, KY 40292; 502/588-5329.

**19-23 — Southern Association for Geriatric Medicine 1st Annual Spring Meeting,** Hotel Vancouver, Vancouver, British Columbia. Contact: Robin Buchanan; 205/945-8425.

**21-23 — Focus on the Chronically Ill Patient,** Sandestin Beach Hilton, Destin, FL. Contact: LaDonna Nail, Southern Medical Association, 35 Lakeshore Dr, Birmingham, AL 35219-0088; 1/800/423-4992; 205/945/1840.

**22 — New Perspectives in Inflammatory Bowel Disease,** Westin Hotel, Cincinnati, OH. Contact: Aaron S. Fink, MD, University of Cincinnati, Dept of Surgery, 231 Bethesda Ave, ML 558, Cincinnati, OH 45267-0558; 513/558-4014.

## JULY

**31-August 4 — Southern Association for**

**Oncology 4th Annual Meeting,** Crystal Palace Resort and Casino, Nassau, Bahamas. Contact: Southern Association for Oncology, 205/942-0530; or SMA Travel, 800/423-4992.

## AUGUST

**7-11 — Southern Orthopaedic Association 8th Annual Meeting,** The Broadmoor, Colorado Springs, CO. Contact: Southern Orthopaedic Association, 205/945-1848.

## SEPTEMBER

**14 — Lasers and Beyond,** presented by N. D. Radtke, MD, and Humana Hospital Audubon. Category I credit. Contact: N. D. Radtke, MD, 240 Audubon Medical Plaza, Louisville, KY 40217; 502/636-2823.

*Come experience the WVSMA Annual Meeting where we combine a world of scientific sessions, medical updates and continuing education with a world of beauty, relaxation and entertainment. That's right, we hold our meeting at the superb, five-star resort known world-wide -- The Greenbrier.*

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*The West Virginia State Medical Association  
124th Annual Meeting*

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Together*





# AKMA Connections

To connect you with the new 1991-92 Auxiliary Executive Committee and Advisory Committee, I am listing addresses and telephone numbers for your ready reference.

## AKMA EXECUTIVE COMMITTEE

*President	Pam Blackstone (Mrs Jack) 3602 Bridge Pointe Owensboro, KY 42303	502/926-4122 (fax) 502/684-4755
*President-Elect	Beryl Dodds (Mrs C. R.) 2625 Club Ct Madisonville, KY 42431	502/821-2741
*1st Vice President	Gloria Griffin (Mrs Larry P.) 8710 Oldbury Place Louisville, KY 40222	502/426-4912
*Central Region Vice President	Angela Watson (Mrs J. Roy) 6500 Woodvail Ct Louisville, KY 40222	502/228-2079
*Eastern Region Vice President	Joyce Clark (Mrs Danny) 8371 Barnesburg Rd Somerset, KY 42501	606/274-4701
*Western Region Vice President	Joan Klompus (Mrs W. H.) 1018 McPherson Dr Madisonville, KY 42431	502/821-5764
*Recording Secretary	Sugar Slabaugh (Mrs Thomas) 2160 Island Dr Lexington, KY 40502	606/269-6872
*Treasurer	Barb Hausladen (Mrs Fred) 5 Woodrun Edgewood, KY 41017	606/341-6216

### AKMA ADVISORY COMMITTEE

Betty Schrodtt (Mrs G. Randolph) 2412 Vallétta Rd Louisville, KY 40205	502/451-8859
Esther Jansing (Mrs C. William) 1915 Littlewood Dr Owensboro, KY 42301	502/684-7337
Carol Franks (Mrs Larry) 3595 Sherwood Rd Paducah, KY 42001	502/444-6092

The Auxiliary to the Kentucky Medical Association is composed of physicians' spouses from throughout the state.

If you would like information about becoming a member, please contact our Membership Chairman, Mrs Larry Griffin (8710 Oldbury Place, Louisville, KY 40222; 502/426-4912), or Jean Wayne at the AKMA Office (3532 Ephraim McDowell Dr, Louisville, KY 40205; 502/459-9790). OR, you may complete the application form below:

#### MEMBERSHIP APPLICATION

SPOUSE'S NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY, STATE AND ZIP CODE \_\_\_\_\_

PHONE NUMBER \_\_\_\_\_

COUNTY \_\_\_\_\_

PHYSICIAN'S NAME \_\_\_\_\_

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8710 Oldbury Place  
Louisville, KY 40222

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# Prevention:

## Rx for Health Care in the 90s

*KMA Annual Meeting · Sept 29 - Oct 3*  
*Hyatt Regency Hotel · Lexington, KY*

The April issue of the *Journal* contained information on the Hyatt Regency Lexington and Lexington Center which will host our Annual Meeting this year, and last month's issue highlighted Lexington's reputation as the "Horse Capital of the World." This month we are placing special emphasis on the arts as Lexington's cultural community continues to prosper.

**ARTSPLACE** — Located in the heart of downtown, ArtsPlace is a multipurpose arts facility boasting dance studios, theater space, rehearsal space, and an art gallery featuring juried shows of work by Central Kentucky artists. ArtsPlace houses a gallery, performance hall, as well as studios and offices for the Lexington Council of Arts and several other organizations.

**HEADLEY-WHITNEY MUSEUM** — Thought of by some as one of Lexington's best kept secrets, the Headley-Whitney Museum offers a variety of cultural experiences to everyone who visits. Located in the midst of bluegrass countryside and picturesque horse farms, the museum is indeed a jewel of a find for any visitor. One can see a variety of fine art collections such as exquisite Chinese porcelain and textile

collections, rare bibelots and unusual objects of nature, and also visit different exhibits which are featured throughout the year.

**LEXINGTON CHILDREN'S MUSEUM** — Located within Victorian Square, the Lexington Children's Museum provides 14,000 square feet of exhibit space making learning a fun and unique experience. Interactive exhibits, programs, demonstrations, and activities are offered for children 12 months to 12 years.

**LOUDOUN HOUSE** — Known for its beauty and historical significance, the Loudoun House offers yet another matchless style for housing art. In 1852, this strikingly different structure became the first castellated Gothic Villa in Kentucky and is one of only six remaining castellated Gothic villas

in the American South on the National Register of Historic Places. Visitors get a chance to become acquainted with the area's visual artists.

Other educational and exceptional museums include the **UNIVERSITY OF KENTUCKY ART MUSEUM**, featuring regularly changing art exhibits; the **UNIVERSITY OF KENTUCKY MUSEUM OF ANTHROPOLOGY**, containing exhibits on the cultural history of Kentucky, kinship, art and religion, archaeology, and physical anthropology, and the **LIVING ARTS & SCIENCE CENTER**.

If visitors prefer a different kind of art, a variety of Broadway plays, concerts and ballet are held at the elegant **LEXINGTON OPERA HOUSE**. Brought back to the glory of more than 100 years ago, this newly refurbished building is the home to many cultural events.

Future issues will feature some of Lexington's historical landmarks and unique shopping areas.

*An exhibit in the Headley-Whitney Museum.*



*America's Best of Show:*

*Lexington*  
 KENTUCKY





**Kenneth W. Crawford, MD, (L)** received a plaque in recognition of his years of service as an **AMA Delegate and Alternate Delegate**. **Board Chairman Cecil D. Martin, MD,** made the presentation.



**Secretary-Treasurer William P. VonderHaar, MD,** addressed the Board.



**The Board endorsed the candidacy of Christa-Marie Singleton for the AMA Medical Student Section Governing Council.**

## Board of Trustees Spring Meeting

**T**he KMA Board of Trustees met on April 10-11, 1991, at the KMA Headquarters Office in Louisville.

The Board members heard reports from the President; the President of the Auxiliary to KMA; the Secretary-Treasurer; the Senior Delegate to AMA; the Secretary of the Board of Medical Licensure; and the Chairman of the Board of KMIC. Other guests who made presentations to the Board included David B. Stevens, MD, Chairman of the KEMPAC Board of Directors; James B. Holloway, Jr, MD, Medical Director, Medicare Part B; Dwight L. Blackburn, MD, Executive Director for Physician Relations, Kentucky Blue Cross and Blue Shield; and David Tao, MD, Medical Director for Sentinel Medical Review Organization.

KMA President, Preston P. Nunnolley, MD, reported on a Health Care Summit held in March, and made a presentation to Ballard W. Cassady, MD, who was retiring as Board Chairman of the Kentucky Medical Insurance Company.

Reports were given by the Chairmen of the Committee on National Legislative Activities and the Technical Advisory Committee on Physician Services. A detailed report was given on the recently completed Special Session of the Kentucky General Assembly, which dealt with such topics as DUI, solid waste

disposal, and the adoption of a Medicaid Assessment Program. Items expected to be introduced into the 1992 Kentucky General Assembly were also discussed.

Direction was given to submit the findings of the KMA Committee on Maternal/Fetal Conflict to the Governor's Task Force on Alcohol and Drug Use During Pregnancy; and to accept the invitation of the Kentucky Center for Public Issues to Endorse "Election 91: Candidate Closeup," which will air individual interviews with Kentucky's gubernatorial candidates on KET.

The Board members adopted a budget for the 1991-92 Associational year; approved a slate of directors to be elected to the KMIC Board, and authorized the KMA Executive Committee and KMA/KMIC Building Committee to determine the best course of action to alleviate space problems in the headquarters building.

The Board also selected names for submission to the Governor for the Kentucky Board of Medical Licensure and the Board of Nursing Advisory Council, and appointed William P. Hoagland, MD, Louisville, to the Editorial Board of the *KMA Journal*.

The Chairman announced that the Board would hold its next meeting in August.

*kma*



*KMA President Preston P. Nunnelley, MD, (L) made a presentation to Ballard W. Cassady, MD, who was retiring as Board Chairman of the Kentucky Medical Insurance Company. Mrs Cassady looked on.*



*AKMA President Betty Schrod presented AMA-ERF checks to the state's two medical schools. (L) Dean Emery A. Wilson, MD, accepted \$19,608.86 for the University of Kentucky, and (R) Dr David Wiegman, Vice Dean for Academic Affairs, accepted \$34,058.15 for the University of Louisville.*



## PEOPLE



KMA staff member **Lillie R. Byrd** was recently honored for 25 years of service.

Lillie came to the Kentucky Medical Association on Monday, April 25, 1966, as a controller in a one-person accounting department. Other duties were varied, or as Lillie puts it, "I did a little bit of everything." She currently serves the Association as Director, Financial Operations.

Lillie received a plaque and a clock in recognition of her service during a luncheon at the Association's headquarters in April.

**Stephen Henry, MD**, orthopedic surgery, received the 1990 Lawrence-Greer Award from the University of Louisville's Student Government Association. The annual award recognizes student government alumni who have made significant contributions to the community since graduation.

The following KMA member physicians were included in recent University of Louisville School of Medicine appointments: **William Daniel, Salem George, Russell Williams**, and **Stephen Self**, clinical instructors, surgery; and **Nelson Rue**, assistant clinical professor, surgery. Also **Thomas Andres**, clinical instructor, emergency medicine; **Jannice Aaron**, assistant clinical professor, diagnostic radiology and assistant clinical professor, neurology; **Daniel Adkins**, assistant clinical professor, family practice; **Peter Isele**, clinical instructor, medicine; **Shelia Roberts**, assistant clinical professor, psychiatry and behavioral sciences; **Barry Wainscott**, assistant clinical professor, psychiatry and behavioral sciences; and **Michael J. Zachek**, additional appointment as assistant clinical professor, family practice.

## UPDATES

## Study Reveals New Data About Vasectomy Reversals

U of L urologist and clinical professor of surgery **Arnold Belker, MD**, spent 9 years studying vasectomy reversals.

Dr Belker and colleagues at four other clinics across the nation studied 1,469 men and found that 52% who had vasectomies reversed were able to father children. The study also revealed that men's chances of helping conceive children were better the sooner they had the sterilization procedure reversed.

The men studied varied in age from 20 to 67. The interval between the vasectomy and the reversal ranged from 1 to 33 years. The results showed men with less than a 3-year interval between vasectomy and reversal had a 97% chance of sperm returning to the semen and a 76% chance of impregnation. The findings

were published in the March issue of the *Journal of Urology*.

The 3-to-8 year success rate is 88% and 53%; 9 to 14 years, 79% and 44%; and 15 years or more, 71% and 30%, respectively.

Men who tried more than once to have their vasectomies reversed met with slightly lower success rates. That's why Dr Belker tells his patients to try again if the first attempt at reversal fails. More than 200 of the 1,469 men studied underwent repeat procedures after a first reversal failed. In these cases, results showed a 75% success rate in restoring sperm to the semen and a 52% impregnation rate.

According to Dr Belker the study broke new ground in the body of knowledge about pregnancy outcome after vasectomy reversal.

It was established that the rate of miscarriage, the rate of children born with congenital abnormalities, and male to female ratio of children are the same after vasectomy reversals as occur in the general population.

## Neurosurgeon, Urologist Team up to Help Children in Pain

U of L pediatric neurosurgeon **Gregory Nazar, MD**, and urologist **Anthony Casale, MD**, have recently been able to restore the health of several children suffering with severe back pain and loss of bladder control. They have found that a simple operation works wonders for children with a disorder called tethered spinal cord.

Victims of the syndrome have abnormal nerve function because of a threadlike filament that anchors the spinal cord to the tail bone. When the filament is too taut, it places tension on the spinal cord and affects the nerves that control the legs, bladder, and bowel.

That was the case with one of Dr Nazar's 10-year-old patients, a girl confined to a wheelchair because of severe pain radiating down her legs.

He performed all the standard tests on the child and found no abnormalities except for a bony defect of the spine called spina bifida occulta. Alone, the defect is harmless, but Dr Nazar knew the defect is often associated with tethered spinal cord. Simple surgery to detach the filum from the spinal cord ended the child's pain and allowed her to return to a carefree life.

According to Dr Nazar the syndrome is difficult to diagnose because no abnormalities turn up in tests or x-rays. In older children the problem is often associated with a physical activity or with a growth spurt that causes even more tension on the inflexible connective tissue filament.

The doctors discovered that even infants can suffer from tethered spinal cord. Babies and toddlers with the disorder often have bowel and bladder dysfunction that make toilet training impossible. Many of the toddlers, as well as the older children, wet their beds at night and experience incontinence during the day.

Dr Casale used a new machine to measure the reflex of the bladder to the spinal cord and back. For children with a tethered spinal cord, tests showed abnormal bladder and bowel reflexes.

Armed with this data, Casale and Nazar were able to give the syndrome a name and offer parents the option of surgery.

Left untreated, tethered spinal cord can cause spinal curvatures, foot deformities and pain in the lower back, as well as change the way children walk. According to Dr Nazar the children had sometimes been subjected to many tests without relief. This often included psychological testing, as older children who start wetting the bed or their pants are often humiliated and their self-esteem suffers.

The doctors have treated 14 children with the disorder in the past

year. Follow-up exams show a great decrease in pain and a great increase in bladder function.

Both doctors said the number of children who need surgery is probably small. They are very selective in determining which patients will benefit from surgery, and if the problems aren't severe, a wait-and-see approach is preferred.

### **Positive Attitude a Great Healer**

**Joel Elkes, MD, and Gabriel Smilkstein, MD,** believe that a patient's mental health is key to his physical health. According to Dr Smilkstein, U of L's William Ray Moore Professor of Family Practice, an individual's outlook on life plays a big role in his ability to deal with illness.

Science has proven that anxiety or stress causes changes in the body's immune and endocrine systems that can worsen chronic health problems such as cardiovascular disease and diabetes.

The outcome of illnesses with a physical cause will be significantly influenced by the patient's attitude and mental health, according to Dr Elkes, professor emeritus in Psychiatry and Behavioral Sciences at U of L.

Elkes and Smilkstein have teamed up to research and document how attitudes influence body function. Included among their colleagues are KMA member physicians **Leah Dickstein, Randall Schrodt, Judith Kupersmith, Clifford Kuhn, Williard Whitehead, and David Casey.**

Grants are providing support for the development of an educational model so medical students and residents can learn how mind/body relationships influence illness and health. Also funds to work with chronically ill patients who may benefit from attitudinal changes.

Patients with rheumatoid arthritis, cancer, asthma, lung disease, low back pain, migraines and other

chronic illnesses will be offered the option of participating in the study.

---

## **AMA BRIEFS**

### **Routine HIV Testing**

In April, the Board of Trustees approved the concept of routine HIV testing of patients. They recommended that hospitals, clinics and physicians should adopt routine HIV testing, depending on local circumstances, and that state medical associations should be encouraged to seek changes of state laws that restrict hospitals' ability to initiate testing programs. The report proposes modification of consent procedures, but it does not advocate that informed consent should be abandoned. Five years ago, routine HIV testing was considered unwarranted and inappropriate because it could lead to discrimination and because of the need for universal precautions, regardless of an individual patient's HIV status. The AMA continues to call for rigorous compliance with universal precautions, but now believes that routine testing may be desirable. Thus, diagnostic testing at the individual physician's discretion should be made simpler.

### **Teen-age Drunk Driving**

The board called for model state legislation to discourage teen-age drunk driving. The best way to make an impression on young drivers is to revoke their licenses, the board said. First offenders under age 21 should lose their licenses for a year; second-time offenders should lose their licenses for 2 years, or until they turn 21, whichever is longer. The board said the AMA should urge state



medical associations to seek enactment of mandatory license revocation in their legislatures.

### Data Bank Revision on Impaired MDs

Voluntary participation in an impaired physician program no longer needs to be reported to the National Practitioner Data Bank, according to a board report that was approved for transmittal to the house. After discussions with the AMA and others, the NPDB changed its guidebook, which now states that "entrance into a drug, alcohol or psychiatric rehabilitation program does not in itself constitute a reportable action." A report is necessary only if there has been a "suspension of a practitioner's license as the result of action based upon professional competence or conduct."

### Hepatitis Vaccinations

The Board of Trustees urged that physicians, medical students and other health care workers be immunized against hepatitis B. Health care workers who have not been immunized have a three- to five-fold higher prevalence of infection than the general population. Two genetically engineered HBV vaccines are available. The policy-making House of Delegates will consider the report at the Annual Meeting in June.

### 1992 Public Health Agenda

The Board of Trustees voted to focus AMA resources on four public health areas next year: HIV and AIDS; substance abuse and smoking; health of specific groups, such as the adolescent and geriatric populations; and interpersonal violence. Supplemental areas of interest will be clinical preventive services, environmental health, and physician health and impairment.

## NEW MEMBERS

*Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.*

### Breathitt

**Verona D. Lawson, MD** — P  
327 Pine Hill Dr, Jackson 41339  
1984, Emory U

### Daviess

**John Howard, MD** — IM  
4312 Brookhill Dr, Owensboro 42301  
1985, U of Louisville

### Fayette

**James A. Henderson, MD** — FP  
Lexington Clinic, Lexington 40504  
1977, U of Kentucky

**Dane K. Hermansen, MD** — U  
Lexington Clinic, Lexington 40504  
1981, Medical College of Virginia

**Periclis Roussis, MD** — OBG  
UKMC, Dept of OB/GYN, Lexington 40536  
1982, CETEC, Dominican Republic

**David A. Sloan, MD** — S  
UKMC, Dept of Surgery, Lexington 40536  
1977, McGill U

### Harlan

**Rafiq U. Rahman, MD** — IM  
Daniel Boone Clinic, Harlan 40831  
1980, Khyber Medical Col, Pakistan

### Jefferson

**Leslie B. Branch, MD** — A  
Ireland Army Hospital, Ft Knox 40121  
1965, U of North Carolina

**James M. Link, Jr, MD** — OBG  
4130 Dutchmans Lane, Louisville 40207  
1986, U of Louisville

### Northern Kentucky

**Eric W. Neils, MD** — R  
170 Barnwood Road, Edgewood 41017  
1983, Case Western Reserve U

### Pulaski

**Amtullah A. Khan, MD** — R  
305 Langdon, Somerset 42501  
1980, Khyber Medical Col, Pakistan

### New In-Training

### Fayette

**Charles W. Bryan, MD** — ONC  
**Ray C. Kennedy, MD** — FP

### Jefferson

**Vernon D. Cook, Jr, MD** — OBG  
**Stephen R. Lincoln, MD** — REN  
**Evan Massey, MD** — IM  
**Stephanie J. Smith, MD** — IM

## DEATHS

**Joseph E. McKinney, MD**  
Maysville  
1909-1990

The *Journal* has just received notification that Joseph E. McKinney, MD, died September 11, 1990. Dr McKinney graduated from the University of Louisville School of Medicine in 1948 and was a life member of KMA.

**Burton A. Washburn, MD**  
Paducah  
1910-1991

Burton A. Washburn, MD, a retired surgeon, died March 3, 1991. Dr Washburn earned his MD from the University of Louisville School of Medicine in 1936 and was a life member of KMA.

**Theodore L. Adams, MD**  
Lexington  
1901-1991

Theodore L. Adams, MD, a retired internist, died March 9, 1991. A graduate of Vanderbilt University School of Medicine, Dr Adams was a life member of KMA.

**Kusum Patel, MD**  
**Hopkinsville**  
**1941-1991**

Kusum Patel, MD, a pathologist, died April 5, 1991. Dr Patel graduated in 1968 from M. S. University of Baroda in India and was a member of KMA.

**Melvin L. Dean, MD**  
**Nicholasville**  
**1914-1991**

Melvin L. Dean, MD, a surgeon, died April 12, 1991. A 1940 graduate of the University of Louisville, Dr Dean was a life member of KMA.

**Charles David Cawood, MD**  
**Middlesboro**  
**1906-1991**

Charles David Cawood, MD, a retired general practitioner, died April 14, 1991. Dr Cawood graduated from the University of Louisville School of Medicine in 1931 and was a life member of KMA.

**Rufus C. Alley, MD**  
**High Point, NC**  
**1901-1991**

Rufus C. Alley, MD, a retired surgeon, died recently. A 1927 graduate of the Medical College of Virginia, Commonwealth University, Richmond, Dr Alley was a life member of KMA.

## CAGE Questionnaire

For the Diagnosis of Alcoholism

- C** = Have you ever felt you should **cut down** on your drinking?
- A** = Have people **annoyed** you by criticizing your drinking?
- G** = Have you ever felt bad or **guilty** about your drinking?
- E** = Have you ever had a drink first thing in the morning (**eyeopener**)?

---

Positive CAGE Answers:

1 = Suggestive 2 = Probable 3 and/or 4 = Diagnostic

---

**KENTUCKY MEDICAL ASSOCIATION**  
**Committee on Impaired Physicians**  
**3532 Ephraim McDowell Drive**  
**Louisville, KY 40205**  
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**COVER:** Lexington, host to the KMA Annual Meeting, Sept 30-Oct 3, has captured a reputation not only as thoroughbred capital of the world, but also as one of America's thoroughbred cities and a first-class meeting and convention site. The area is replete with history, charm, upscale shops, and cultural enticements. Pictured clockwise — the Hyatt Regency which will house this year's meeting; a pastoral scene of thoroughbreds in the early dawn; Lexington's beautiful skyline — all against a backdrop of one of Lexington's world famous horse farms.

See page 342 for more information on your Annual Meeting.

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## Prosecution or Persecution?

Just when we thought malpractice was the worst thing that could happen, we have now reached a new milestone in physician harassment. Criminal indictments against physicians are beginning to become a national trend. Most of these indictments are a result of occurrences which heretofore have been addressed by standard malpractice lawsuits.

Recently the *Miami Herald* carried a front page article entitled, "Florida Physician Indicted on Manslaughter Charges." The article, later carried by the *American Medical News*, related how Jack Swords, MD, became the first physician to be indicted on a manslaughter charge for treatment of a patient. The indictment stated, and I quote, "Jack Swords, MD, did unlawfully by act, procurement, or culpable negligence and without lawful justification kill a human being . . . by failing to provide necessary medical care, and said killing was not an excusable

homicide nor murder. . . ." Doctor Swords' patient had a history of strokes and suffered from Alzheimer's and diabetes. As in most malpractice situations, there are conflicting opinions regarding the cause of

death. According to the state's medical expert, however, the patient died because of uncontrolled diabetes. If convicted, Dr Swords faces a 15-year prison sentence.

In the April 21 issue of *American Medical News*, Robert Gordon, the former New York City police officer who investigated the case on behalf of the state, compared the prosecution of physicians with the prosecution of Los Angeles police officers accused of beating a motorist. Mr Gordon stated, "By the same token, physicians are not above the law." The comparison of an intentional beating of an unarmed man with alleged improper medical care is astounding. Everyone agrees that a crime was committed in Los Angeles. In most criminal cases, the issue is who did it. In Dr Swords' case in Florida, however, there is extreme doubt that a crime occurred. There are expert opinions that Doctor Swords' treatment of the patient was proper. No one suggests that doctors

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***"No health care professional will practice anything other than the most defensive and expensive medicine if a second-guessing prosecutor can file criminal charges based on subjective hindsight."***

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— RONALD L. DYER

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***“Most criminal cases center around care for the elderly. If prosecuted successfully, this may dramatically reduce availability of health care services for the elderly. This comes at a time when health care requirements of the elderly are increasing dramatically.”***

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should be above the law. But unless there is a harmful intent, there should be no criminal prosecution.

In Indiana, a physician was recently indicted for neglect of two elderly nursing home patients. One of the patients died due to complications of gangrene. In spite of the fact that the Indiana General Assembly refused to include health care providers under the statute, the Indiana Attorney General is attempting to prosecute the physician as a test of the state's dependent laws. Previously, the statute has been limited to the prosecution of family members who neglected to arrange for adequate care of their dependents. Indiana's neglect of dependents statute has never been successfully applied to a health care provider. If convicted, the physician faces a 4-year sentence and a \$10,000 fine.

In another Indiana case, a physician has been charged with reckless homicide and faces a 2- to 8-year prison sentence if convicted.

This type of physician

harassment is not only devastating from a psychological and professional standpoint, it also presents serious financial burdens for the physician.

Criminal defense costs must be borne by individual physicians because malpractice policies generally exclude coverage for criminal acts. Furthermore, carriers may defend the physician's simultaneous civil malpractice suit under a "reservation of rights." This reservation allows a carrier to deny coverage for civil damages if physicians' actions rise to the level of criminal conduct. Therefore, the carrier could refuse to pay a judgment awarded in the malpractice case if the physician receives a criminal conviction.

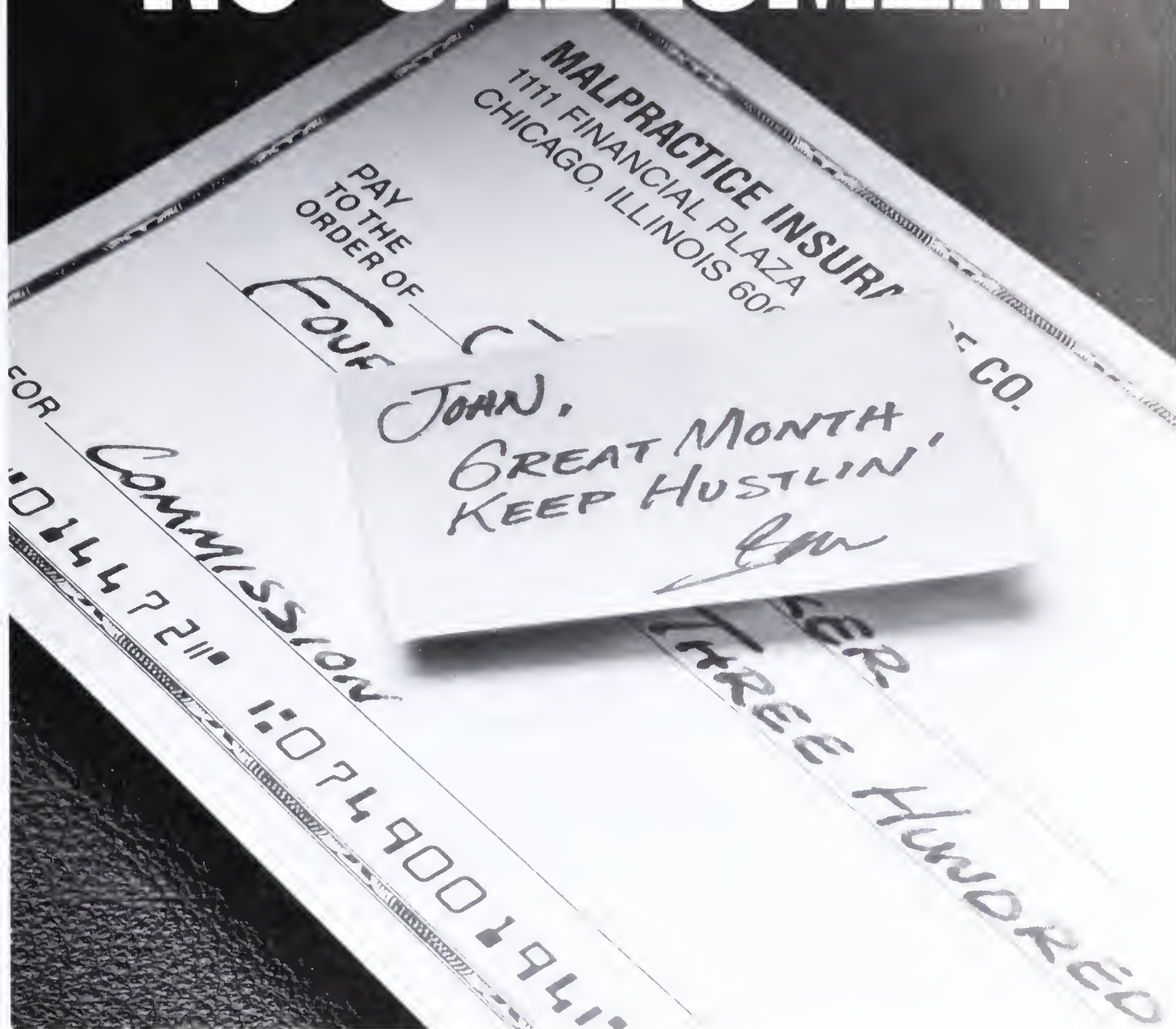
Most criminal cases center around care for the elderly. If prosecuted successfully, this may dramatically reduce availability of health care services for the elderly. This comes at a time when health care requirements of the elderly are increasing dramatically. The elderly represent the fastest growing segment of our population. It also presents itself at a critical time when medicine is under attack due to increasing health costs.

This issue is best summarized by Ronald L. Dyer, General Counsel to the Indiana Medical Association. Mr Dyer states, "No health care professional will practice anything other than the most defensive and expensive medicine if a second-guessing prosecutor can file criminal charges based on subjective hindsight."

If we are to continue to give quality care to our elderly and control rising costs of health care, this type of harassment of physicians must not be allowed to continue.

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# Fraud and Abuse Liability in the Health Care Profession

Sheldon G. Gilman, Esq

A provider of health care services should be sensitive to the very real potential for liability for fraudulent and abusive practices under the Medicare and Medicaid programs and commercial health insurance programs. The recent enactment and ever-increasing enforcement of a comprehensive web of criminal, civil, and administrative laws and regulations has raised the spectre of liability among providers of health services.

A number of questions are continually raised concerning prohibitions under the fraud and abuse laws because of their complexity and the considerable uncertainty about their application to given circumstances and business practices. This article reviews the major criminal and civil fraud and abuse authorities in an attempt to provide insight into the enforcement of these laws and their objective to minimize fraud and abuse and to reduce costs in government and private health insurance programs.

Abuse occurs when a provider *unknowingly* overcharges Medicare or the patient, typically involving the over-utilization of medical services. Fraud occurs when there is an *intentional* deception or misrepresentation that could result in an unauthorized benefit being paid.

The most basic fraudulent practice is the submission of false claims for the payment of services or goods which were not rendered or provided. The submission of claims for payment for more complex medical procedures than those actually performed and the practice of double billing or padding bills have also been a frequent basis for the enforcement of the fraud and abuse laws. An alleged common practice in the health care industry, and one viewed as perhaps the most costly by governmental and private health insurance payors, involves kickback arrangements between providers and suppliers of health care goods and services and their referral sources. The abusive practices which authorities traditionally have focused on are those which are most prone to induce over-utilization of health care services.

The basic thrust of these laws is premised on the principle that payment for health care is only available for services that are medically necessary, efficient and economical, and of a level of quality recognized in the community. The statutory and regulatory framework available to ensure that these goals are met include (1) recoupment of money "overpaid" to providers and suppliers of health care goods and services which are deemed to be medically unneces-

sary or unreasonable, (2) suspension of providers and suppliers from public and private health insurance programs, and (3) criminal and civil penalties.

The most severe application of the fraud and abuse laws has been seen in criminal prosecutions for making, or causing to be made, false statements or representations in a claim for payment under the Medicare and Medicaid programs. The standard under this statute requires a knowing and willful false statement or representation of a material fact which is made or applied in the determination of the right to receive payment of benefits. The penalties under this statute include fines of as much as \$25,000 or imprisonment for not more than 5 years or both. A number of other federal statutes have also been applied in conjunction with this law to enforce the prohibition against false claims, including the False Claims Act, the False Statement Act, the mail fraud statute, and the conspiracy statute involving fraud against the government.

The prohibitions regarding over-utilization and kickback arrangements are more grey than black and white; accordingly, appropriate caution is for any provider involved in a referral relationship when any form of remuneration, in cash or in kind, direct or indirect, overt or covert, passes between the parties



and could possibly be construed as an inducement for the referral of new business. A decision by the US Court of Appeals for the Third Circuit in 1985 created uncertainty when it concluded that if payments to referring sources were intended in any way to induce a provider or supplier to use a particular individual or entity (a determination often based on circumstantial evidence), then a violation of the statute has been committed. Liability in payment for referrals *was also intended to compensate for a bona fide professional service by the source of the referral.*

The Secretary of Health and Human Services has been mandated by Congress to promulgate "safe harbor" regulations which would identify specific practices and business relationships which could be followed without incurring liability under the anti-kickback statute.

Although a draft of the Safe Harbor regulations (defining what is clearly not a kickback) has previously been leaked to the public, publication of final regulations has been delayed several times.

According to the "leaked" draft of the proposed Safe Harbor regulations, limited partnerships cannot (1) have more than 50% of each class of investments held by investors who are in a position to make or influence referrals; and (2) receive more than 50% of their annual revenues from referrals generated by investors. There is a great deal of uncertainty regarding what the phrase "each class of investments" means. The 50% test could be interpreted to apply to all separate classes of limited partnership investors, including hospital management employees and physicians. On the other hand, investments offering an equal interest in distributions, profits and losses, even though calling for different voting rights, etc, might meet the definition.

Notwithstanding the 50-50 rule, there is a proposed additional safe harbor which would allow physicians to refer patients to entities in which they have an ownership interest if:

1. The referring investor personally provides the medical treatment;
2. The investors are not offered better investment terms based on referrals;
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5. The payments to the investors are not based on referrals; and
6. The referring investor does not serve as consultant or does not merely provide incidental services.

There is also a provision in the law governing the Medicare and Medicaid programs which requires local insurance carriers to ensure that the payments are for services which are reasonable and medically necessary and are documented by the necessary payment information. The incredibly large volume of claims for payment, however, renders it infeasible for carriers routinely to require full documentation of every claim prior to payment. The carriers instead rely, in the first instance, on the physician's certification on the health insurance claim form that the services are reasonable and medically necessary. This certification requirement on each health insurance claim form puts the certifying doctor on notice that payment for the claim will be valid but only for those services which are reasonable and medically necessary.

The determination of whether the services are reasonable and medically necessary is done on a retrospective basis within the 6-year statute of limitations, and this allows the government to seek recovery of the amount of payments initially made for medically unnecessary and unreasonable services. The carrier makes this determination by comparing a provider's practice and prescriptions to the prevailing practice of similar practitioners in the local geographical area. Accordingly, a substantial overpayment determination can be made by the government long after the services are rendered and the claims are originally paid. Furthermore, when the government determines, or reliably

suspects, that an overpayment has been made, either because of the accumulation of medically unnecessary and unreasonable services or evidence of fraud or abuse, it may suspend current payments to the provider and begin es-crowing these funds without notice and right to a hearing.

Overpayment liability requires a particular sensitivity to what constitutes medically necessary and reasonable goods and services. The issue of medical necessity and reasonableness with respect to services provided by physicians has already been identified as a matter of comparing a particular physician's practices with those of the physician's peers in the relevant geographic area.

Numerous authorities comment that providers should seek counsel before discovering that commonly accepted practices and relationships now subject them to liability. This is overly simplistic as definitive guidelines are *not* available and the Department of Health and Human Services adamantly refuses to respond to requests for private advisory rulings. In many cases, the health provider now determines what constitutes fraud and abuse on an after-the-fact basis. In Kentucky there is a possibility for some relief. The Cabinet of Human Resources and the Kentucky Medicaid Fraud and Abuse Control Division will, on occasion, issue advisory opinions, and these opinions will serve as a defense if the applicant relies on the advice of the Cabinet.

In summary, conscientious diligence is an understatement. A conscientious concern and a review of every aspect of a physician's business practices must continue to be monitored at the same time the physician monitors his patient's health.

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*Mr Gilman is a principal in the law firm of Lynch, Cox, Gilman & Mahan PSC, 500 Meidinger Tower, Louisville, KY 40202.*

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# Epidural Morphine Pruritus Reduction with Hydroxyzine in Parturients

Mushtaque M. Juneja, MD; William E. Ackerman III, MD;  
Kathleen Bellinger, RN

*A majority of patients experience pruritus, nausea and/or emesis following epidural morphine administration post-cesarean section. Naloxone or diphenhydramine are commonly used to treat these side effects. Prevention or reduction in the incidence of side effects of epidural morphine is a clinical goal. The purpose of the study was to observe the efficacy of prophylactic administration of hydroxyzine on the incidence and severity of pruritus following the epidural administration of morphine in 40 patients who requested epidural morphine for postoperative pain relief. Group I (n=20) received saline, while Group II (n=20) received 50 mg of hydroxyzine ten minutes after the administration of 5 mg epidural morphine. Both solutions were administered by deep intramuscular injection in the thigh area. The results of this investigation demonstrated that hydroxyzine was efficacious in attenuating the incidence of severe pruritus.*

## Introduction

Epidural morphine can produce adequate analgesia which may last 4 to 36 hours in 83% of postoperative cesarean section patients but the incidence of pruritus approximates 68%.<sup>1,2</sup> Pruritus may be treated effectively with either naloxone or diphenhydramine.<sup>3,4</sup> Following the epidural administration of morphine, the incidence of pruritus occurs more frequently in parturients.<sup>5</sup> Korsh et al reported that generalized histamine release did not occur following epidural morphine administration to post-cesarean section patients but that a local tissue histamine release could not be ruled out.<sup>6</sup>

Hydroxyzine possesses not only antihistamine, but also antipruritic and antiemetic properties. The review of literature did not reveal any research which examined the effect of hydroxy-

zine on the incidence of pruritus caused by epidural morphine. The purpose of this study was to assess the efficacy of prophylactic administration of hydroxyzine to prevent pruritus in post-cesarean section patients who received epidural morphine for the control of postoperative pain.

## Methodology

Institutional Review Board approval was granted and informed consent was obtained from each patient who participated in the study. Forty patients classified ASA I or II who were scheduled for elective cesarean section delivery and who had requested epidural anesthesia were the subjects for the investigation. Patients with a history of pruritus, skin lesions, steroid or antihistamine therapy within 4 weeks of the surgery were excluded from participation as subjects. All patients were hydrated prior to epidural catheter placement with 1500 ml of Lactated Ringers solution. Each epidural needle was placed at the L2-3 or L3-4 interspace, and each epidural catheter was advanced 2 to 3 cm into the epidural space. Epidural anesthesia was established to a bilateral T4 sensory level as determined by pinprick using 2% lidocaine with 1/200,000 epinephrine. The patients were randomly assigned to one of two groups. Group I (n=20) was the control group; each subject received 1 ml of sterile normal saline via intramuscular injection 10 minutes after the administration of the epidural morphine. Group II (n=20) was the treatment group; each subject received 50 mg hydroxyzine via intramuscular injection 10 minutes after the administration of epidural morphine. All study solutions were administered in a double-blinded fashion. To standardize epidural dosing, all subjects in Group I and Group II received 5 mg of epidural morphine without preservatives for analgesia.

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## Epidural Morphine Pruritus Reduction

Table 1. Maternal characteristics<sup>a</sup>

	Group I	Group II
Age (yrs)	22 (3)	23 (2)
Height (cm)	164.32 (6.3)	163.2 (6.3)
Weight (kg)	82.6 (6.8)	81.8 (10.8)
Gravidy	2 (1)	2 (1)
Parity	1 (1)	1 (1)

<sup>a</sup>Values are mean  $\pm$  SD.

Table 2. Incidence of Pruritus

	Group I	Group II
Total Number (n)	20	20
Pruritus (n/%)		
None	2/20 (10%)	5 (25%)
Mild to moderate	9/20 (45%)	13/20 (65%)
Severe	9/20 (45%)	2/20 (10%)*
Site of pruritus		
Face only	2	1
Trunk only	1	1
Face and trunk	16	13

\*p &lt; 0.05

Each subject was interviewed at 12 and 24 hours after the treatment by a blinded observer who did not participate in the treatment part of the research. The patients were questioned regarding: (1) the incidence of pruritus; (2) the site and time pruritus occurred; (3) the severity of the pruritus (mild to moderate which required no treatment and severe which was treated with diphenhydramine 25 mg given intramuscularly). A pruritus score was used: 0 = no pruritus; 1-3 = mild pruritus; 4-7 = moderate pruritus; 7-10 = severe pruritus. A pruritus score of 10 was the worst itching ever experienced.

Statistical analysis was performed using the student's t test and the chi square contingency table where appropriate. There were no differences in age, height, weight, gravidity or parity between the patients in the two groups of subjects (Table 1). In Group I, control, 9 of 20 patients reported severe pruritus that required treatment. In Group II, treatment, 2 of 20 patients required treatment for pruritus (Table 2). The incidence of mild to moderate pruritus did not differ significantly. A higher incidence of nausea and emesis was noted in Group I.

## Discussion

This research demonstrated that the prophylactic administration of hydroxyzine was effective in preventing severe pruritus associated with epidural morphine administration in one sample of patients who had a cesarean section. Pruritus not only causes patient discomfort but could ultimately be associated with a potentially serious medical complication. It has been reported that epidural morphine may be associated with reactivation of the herpes simplex virus labialis (HSV-L) in the parturient.<sup>7,8</sup> Herpes simplex encephalitis caused by HSV-L is an uncommon disease which can be linked with severe morbidity and high mortality. Most often it results from reactivation of the HSV-L virus.<sup>9</sup> The mechanism of HSV-L reactivation is unknown but may be caused by a skin trigger mechanism (ie, scratching).<sup>10</sup> Nausea and/or emesis can also occur following epidural morphine administration. Furthermore, results of this research show that investigation of prophylactic hydroxyzine administration is warranted to decrease the incidence of nausea and/or emesis associated with epidural morphine administration.

Hydroxyzine possesses antihistamine, anticholinergic, antispasmodic, antiemetic and weak local anesthetic activity.<sup>11</sup> The mechanism by which hydroxyzine exerts its antiemetic effect is unknown but may be related to central antimuscarinic actions and/or its action on the medullary chemoreceptor trigger zone.

The mechanism by which hydroxyzine exerts its antipruritic effect is also unknown. Hydroxyzine may attenuate the local tissue release of histamine or it may exert an inhibitory effect centrally in the "scratch center" which is thought to be located in the floor of the fourth ventricle of the brain.<sup>12</sup> Because diphenhydramine and naloxone have each been reported to relieve pruritus, it is suggested that in some patients there may be more than one etiology of pruritus following epidural morphine administration.<sup>13</sup>

Because of the high incidence of pruritus associated with epidural morphine in post-cesarean section patients, it is concluded that the prophylactic administration of hydroxyzine may be useful in this patient population. Further clinical research is indicated to attempt to identify the etiology of pruritus, nausea, and/or emesis in patients who have received morphine via the epidural route.

In post-cesarean section patients with a his-

tory of recurrent HSVL, intramuscular morphine might be considered as an alternative to epidural morphine for postoperative pain management. It has been reported that patients who received intramuscular morphine and who had a positive history of HSVL did not report a recurrence of the disease postoperatively.<sup>8</sup>

Currently multiple prospective investigations are being conducted that may provide empirical evidence concerning clinical treatments that produce the desired analgesia for post-cesarean section patients with a decreased incidence of side effects such as pruritus. Additional increases in patient comfort and safety are expected long range results from continued research in this area.

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# Bronchogenic Carcinoma and the Acquired Immunodeficiency Syndrome

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*The majority of patients with the acquired immunodeficiency syndrome will develop clinical and radiographic pulmonary involvement during the course of their disease. Although opportunistic pathogens account for the majority of these intrathoracic abnormalities, pulmonary neoplasms are being encountered more often than would be expected for the age group under consideration. Clinicians need to be vigilant for the possibility of the early appearance of bronchogenic carcinoma in this subset of patients.*

## Introduction

Since its recognition in the United States in 1983, investigators have speculated that malignant tumors might occur with increased frequency in those patients whose immune system was impaired by the HTLV-III retrovirus.<sup>1</sup> Indeed, the occurrence of certain solid tumors and lymphomas has been observed in this population which lacks the usual risk factors.<sup>2</sup> Pulmonary involvement with malignant B-cell lymphoma and Kaposi's sarcoma has been well documented, although the reason for the increased frequency and biologic aggressiveness of these tumors is still not clear. As experience with the acquired immune deficiency syndrome (AIDS) increases, primary bronchogenic neoplasms are being recognized more often than expected in this young subset of our population.

We report the occurrence of adenocarcinoma of the lung with pleural involvement in a young homosexual male with AIDS and review the current medical literature that suggests that the development of primary lung carcinoma may be promoted by the HTLV-III retrovirus.

## Case Report

The patient, a 34-year-old white homosexual male, initially presented to his private physician with

complaints of dyspnea and right lateral chest pain. He denied hemoptysis, paroxysmal nocturnal dyspnea, and orthopnea. He also denied fever, chills, nausea, vomiting or diarrhea. He was advised that he had radiographic evidence of a right-sided pneumonia and was prescribed doxycycline after he refused hospitalization.

His symptoms did not improve after 2 weeks of oral antibiotic. Sputum samples obtained from his first visit were negative for bacterial pathogens, acid fast bacilli, and fungi. A repeat chest radiograph confirmed the persistence of a right lower lobe consolidation and the new appearance of a pleural effusion. Thoracentesis was performed by his primary physician. Blood tinged exudative fluid was obtained that contained 200 white blood cells with a lymphocyte predominance and a glucose of 14 mg/dl. A diagnosis of tuberculous pleuritis was entertained and the patient was referred to University Hospital for further workup.

The patient's social history indicated that he had been in a monogamous homosexual relationship for 5 years. Prior to this, he had had multiple sexual partners. He denied intravenous drug use and had never received blood transfusions. He had an insignificant history of tobacco use and worked as a respiratory therapist in New Orleans, LA.

His oral temperature was recorded as 98.2°F. Respirations were 26 breaths per minute with some splinting on the right side. Pulse was 100 beats per minute and blood pressure was normal. This thin male was in mild respiratory distress. The oral mucosa was covered with the whitish plaques. Breath sounds were decreased on the right side and absent in the right posterior base. There was dullness to percussion in the right base and absence of tactile fremitus consistent with the presence of pleural effusion. The remainder of his physical examination was normal.

Admission laboratory data was remarkable

for antibody to the HTLV-III virus and identification of *Candida albicans* from the oral plaques. Arterial blood gas analysis measured the  $\text{PaO}_2$  at 67 torr,  $\text{Paco}_2$  at 30 torr, and the pH at 7.43. His hemoglobin was 12.3 g/dl and his white blood cell count was 6,600/ccm. Induced sputums were negative for all pathogens, with special attention given to AFB, fungus, and *Pneumocystis carinii*.

A right lung infiltrate and pleural effusion were present on the chest radiograph. A CT scan of the chest indicated that this pleural effusion was loculated (Fig 1). A chest tube was placed and cloudy red exudative pleural fluid was removed from the right chest. Because this fluid contained no pathogens or abnormal cytology, a thoracotomy with open pleural biopsy was performed (Fig 2). A poorly differentiated adenocarcinoma of the lung involving the right pleura was found.

His postoperative course was complicated by deep venous thrombosis of the left lower extremity and suspected recurrent pulmonary embolism. The patient expressed his desire that no resuscitation or mechanical ventilation be performed. He expired 1 month after his diagnosis from progressive respiratory failure unresponsive to conservative therapy.

## Discussion

An increased incidence of cancer in immunodeficient individuals, such as those with the congenital Wiskott-Aldrich syndrome, is well recognized.<sup>3</sup> Likewise, investigators have noted an increased incidence of secondary neoplasms in those individuals who have received cytotoxic or immunosuppressive therapy<sup>4</sup> and those with certain autoimmune disorders.<sup>5</sup> Since animal retroviruses have historically been associated with the induction of neoplastic disease,<sup>6</sup> many authorities anticipated an increase in lymphomas and solid tumors when the HTLV-III retrovirus was identified as the pathogen causing the acquired immunodeficiency syndrome (AIDS).<sup>2</sup>

The association between immunosuppressed individuals and neoplasm is most commonly expressed as lymphoreticular malignancies.<sup>6</sup> Immune dysfunction as a consequence of CD4 T-cell loss in AIDS has resulted in an increased occurrence of Kaposi's sarcoma, Hodgkin's lymphoma, B-cell derived lymphomas, and less commonly, T-cell derived lymphomas. The CD4 T-cell is a major target of the HTLV-III retrovirus, now referred to more commonly as the Hu-



**Fig 1** — CT scan shows collapse of the right middle and lower lobes with air bronchograms. Pleural effusion is present anteriorly and posteriorly.



**Fig 2** — Bilateral pulmonary disease prior to patient's death.

man Immunodeficiency Virus (HIV). It remains speculation whether these neoplasms are a result of viral oncogenesis or due to depressed immunologic surveillance.

The gene sequence of HIV also causes increased proliferation (hyperplasia) of epidermal cells.<sup>7</sup> A variety of solid neoplasms have now been



## Bronchogenic Carcinoma &amp; AIDS

**Table 1.** Previously reported cases of bronchogenic carcinoma in AIDS patients.

Adenocarcinoma	Squamous cell	Small cell	Mesothelioma	(reference)
4	1	1	0	(9)
4	1	2	1	(10)
0	0	1	0	(11)
1	0	0	0	(12)
0	0	1	0	(13)
9	2	5	1	total = 17

documented in the AIDS population. Squamous cell carcinomas of the oral cavity and anorectum have been increasingly observed in AIDS patients.<sup>8</sup>

Each of the major histologic cell types of bronchogenic carcinoma have been reported in the AIDS population (Table 1). The radiographic presentation of the pulmonary cancer does not differ from the classic radiographic manifestation of lung cancer, but the biologic aggressiveness of these tumors is noteworthy. Although occurring at a younger age than lung cancer in the general population, the advanced stage of the cancer at the time of diagnosis in the AIDS patients is alarming and uniformly portends a poor outcome.

Braun et al<sup>9</sup> have reported one of the larger series of lung carcinoma observed in HIV seropositive patients at their institution and estimate a 14-fold increased risk of bronchogenic neoplasm compared to the overall risk in the general population. Importantly, the tumors present in these young patients without a family history of lung cancer or known lung cancer risks. Their analysis is the strongest evidence that the frequency of lung cancer is increased in patients with AIDS.

The diagnosis of primary bronchogenic neoplasm in these patients may be delayed because they are in a younger age group than usually suggests lung cancer. The case presented suggests the need to consider the diagnosis of primary bronchogenic carcinoma in AIDS patients, in addition to the many pulmonary opportunistic in-

fections and the above mentioned lymphoreticular intrathoracic malignancies. Likewise, analysis of pleural effusion in the AIDS population should routinely include cytologic examination for malignant cells. Some consideration should also be given to evaluation of the immune system of young patients who develop bronchogenic carcinoma without known cancer risk factors.

As with all neoplasms associated with the HIV induced immunodeficiency state, further research will be required to define whether the virus promotes malignant transformation or merely alters the host's ability to contain naturally occurring neoplastic transformation. Greater clinical awareness of the potential for unusual neoplasms in the AIDS population will provide further insight into this association.

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# Familial Cardiac Amyloidosis

## Diagnosis by Immunocytochemistry

Robert L. Sasser, MD; Steven M. Smith, MD; Glenn Morris, DO;  
Douglas Ackerman, MD

*Familial cardiac amyloidosis is a rare disorder that is difficult to diagnose. There is no specific therapy for this disease, but it is important to distinguish the cardiac and gastrointestinal symptoms of this disease from those of other treatable causes. We have treated a patient with this disorder who presented with cardiac and gastrointestinal symptoms. The diagnosis of amyloidosis was suspected on rectal biopsy and was confirmed by immunocytochemistry and immunoalkaline phosphatase technique. Pre-albumin was demonstrated in the lesion. We concluded that when familial amyloidosis is suspected, a biopsy from the suspected organ system is helpful for the diagnosis. The detection of pre-albumin by immunocytochemistry can elucidate the diagnosis of familial amyloidosis.*

### Introduction

Familial amyloidosis is a group of rare diseases characterized by polyneuropathy and by signs and symptoms referable to many organ systems. It is subdivided into the Portuguese (Type 1), Indiana/Swiss (Type 2), and Jewish (Type 3) subtypes.<sup>1</sup>

The diagnosis of familial amyloidosis is difficult to establish and treatment is only symptomatic. Nevertheless it is very important to distinguish cardiac and gastrointestinal symptomatology secondary to familial amyloid deposits from other treatable causes.

Recently Olson et al<sup>2</sup> studied a large group of patients with amyloidosis. They used an immunochemical method to identify the immunoglobulins and pre-albumin and were able to accurately diagnose and classify amyloidosis. We also used a similar technique to study a patient who presented with gastrointestinal complaints and cardiac arrhythmia and established the diagnosis of a variant of Type 2 amyloidosis by demonstrating pre-albumin on a rectal biopsy.

### Case Summary

This 66-year-old white male presented with an 18 month history of diarrhea and a 30 pound weight loss over 6 months. He also had a history of bilateral carpal tunnel syndrome. His family history was significant for amyloidosis with cardiac involvement. Many of his family members had severe motility problems of the gastrointestinal tract, including diarrhea, and fetal cardiac arrhythmias in their fifth and sixth decades of life.

Pertinent physical findings included a grade 2/6 systolic murmur which was best appreciated in the second intercostal space at the left sternal border with radiation to the apex. There was physiologic splitting of S2 and there were no gallops. There was moderate hepatomegaly and trace of pedal edema. The complete blood counts and biochemical tests of his blood were unremarkable. The two-dimensional echocardiogram showed concentric left ventricular hypertrophy and slightly thickened mitral and tricuspid valves. Electrocardiogram revealed a first degree A-V block with a left anterior fascicular block and poor R wave progression. The rectal biopsy was diagnostic of amyloidosis.

The patient was treated with supportive measures and discharged. He continued to have intermittent diarrhea and was subsequently rehospitalized for malnutrition and a left intertrochanteric fracture. He developed refractory congestive heart failure and expired.

### Immunochemical Studies and Autopsy Findings

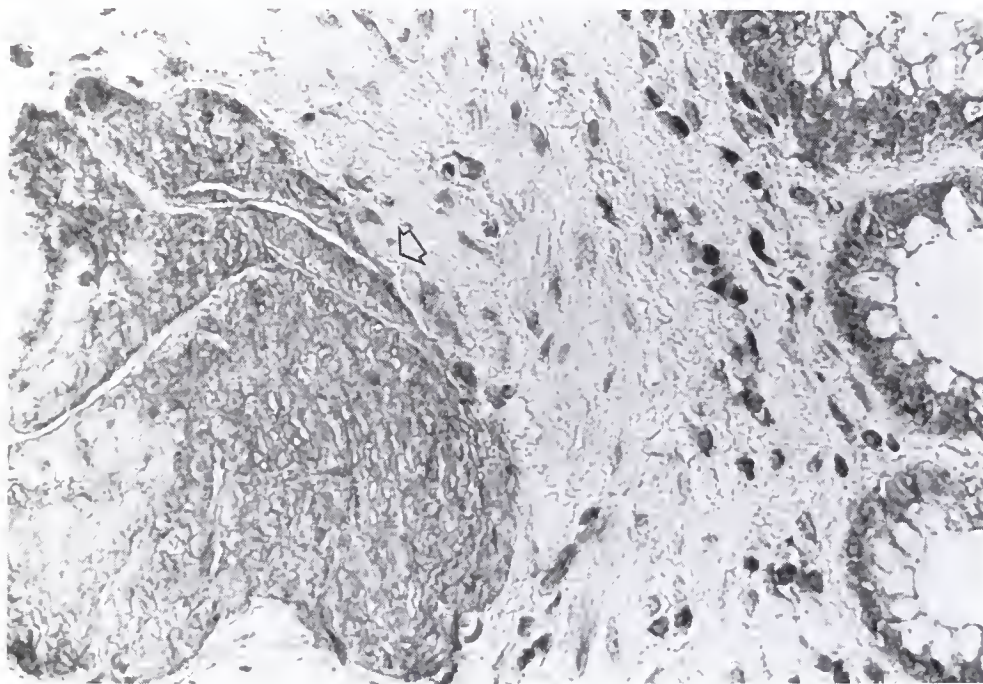
#### Immunochemical Studies:

Rectal biopsy was obtained for conventional histologic and special immunochemical studies. Sections stained with hematoxylin and eosin revealed the classic dense amorphous eosinophilic submucosal vascular wall amyloid deposition which was positively stained with sulfated Alcian

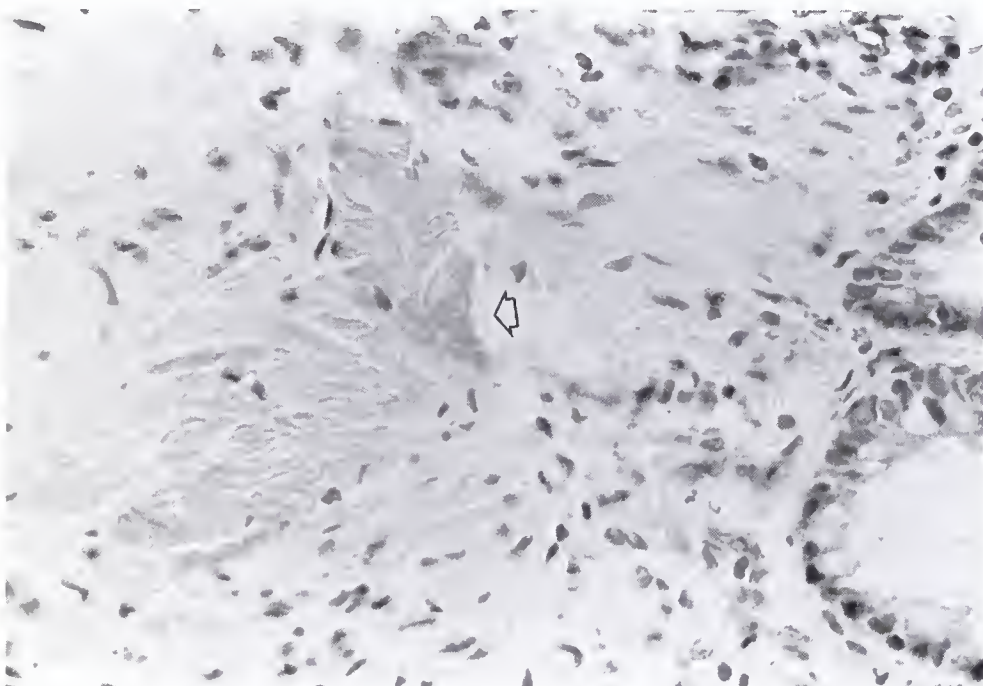
*From the University of Louisville School of Medicine, Louisville, KY 40292.*



## Familial Cardiac Amyloidosis



**Fig 1** — Section of rectal biopsy showing amyloid deposits (arrows) in the submucosal layer (Congo Red stain,  $\times 512$ ).



**Fig 2** — Section of rectal biopsy stains for pre-albumin showing intense stains (arrows) at the site of amyloid deposit (Immunoalkaline phosphatase method,  $\times 512$ ).

Blue and Congo Red (Fig 1). The same biopsy, when stained with Congo Red, revealed the classic apple-green birefringence under polarized light. These same vascular deposits stained strongly for pre-albumin (Fig 2) via specific an-

tibodies labeled with immunoalkaline phosphatase.<sup>3</sup> Similar stains for kappa and lambda light chains were negative.

#### Autopsy Findings:

The most striking finding at autopsy was massive cardiomegaly [(wt = 600 gms (nl = 340 gms  $\pm$  40))] with the characteristic rigid waxy and fatty ventricular walls (Fig 3). The amyloid deposition diffusely involved all four cardiac chambers and imparted a honey-dewdrop appearance to the entire endocardial surface including all of the valve leaflets and cusps (Fig 4). Viscera deposits were diffuse but predominantly microscopic, causing no other grossly appreciable visceral disfigurement. Histologic documentation of vascular and parenchymal amyloid was noted in the liver, pancreas, adrenal glands, lungs, testes, kidneys, prostate, bladder, skeletal muscle, bone, and the entire gastrointestinal tract.

Other pertinent autopsy findings included acute bilateral bronchopneumonia, fibrinous pleuritis, and moderate to severe systemic atherosclerosis.

#### Discussion

Amyloidosis is defined as extracellular deposits of the fibrous protein amyloid in one or more body sites.<sup>4</sup> It is a heterogeneous disorder and can be divided into three subsets. Primary amyloid involves deposition of the protein fibril composed of immunoglobulin light chain. Secondary amyloid results from a chronic inflammatory process, ie, osteomyelitis, tuberculosis, and the major protein component is protein A. The final subset is termed familial, in which the major protein is pre-albumin.

Based on clinical features, familial amyloidosis can be classified into three subtypes. Type 1 manifests as a lower limb neuropathy and renal involvement. Clinical characteristics for Type 2 include cardiomyopathy, carpal tunnel, peripheral neuropathy, and vitreal deposits with blindness. Type 3 is characterized by lower limb neuropathy, renal involvement, and vitreous deposits with blindness. These subtypes are dependent on the substitution of amino acids in the pre-albumin molecule. The clinical presentation varies with the type of amyloid. Our case is a variant of Familial Amyloid Polyneuropathy (FAP) Type 2 as described by Benson.<sup>1</sup> The clinical presentation involves cardiomyopathy or fatal arrhythmias occurring in the fifth or sixth decade. Gastroin-



testinal tract motility problems also occur. Carpal tunnel syndrome may precede the above symptomatology by several decades.

The problem with diagnosis of amyloidosis is that conventional staining techniques cannot distinguish between primary, secondary, or familial amyloid. Hematoxylin and eosin will stain amyloid as a pinkish amorphous configuration. Congo Red also has its characteristic staining as previously discussed under light and polarized microscopy, but cannot distinguish between the separate subsets.<sup>5</sup> Immunocytochemistry is able to differentiate the subsets. Primary amyloid will produce monoclonal light chain immunoglobins to which a monoclonal antibody with an indicator can be derived. The same is true for secondary and familial amyloid to which a monoclonal antibody can be developed to the major protein component.

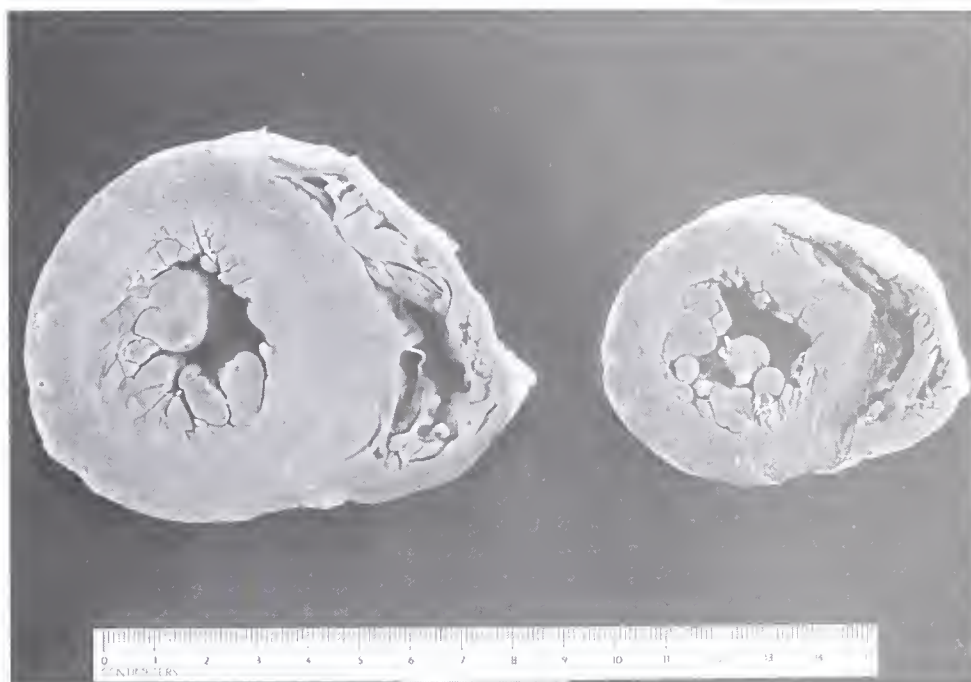
### Summary

It is very important to distinguish between the different subsets of amyloid because the treatment varies according to the type of amyloid present. Primary amyloid treatment, if secondary to multiple myeloma, is directed to effective chemotherapy for the malignancy. Likewise, treatment for secondary amyloid involves identifying the infectious or inflammatory process and treating appropriately. Therapy for familial amyloid is symptomatic only. Therapy for the variant Type 2 FAP, as in our patient, was very ineffectual. It is therefore essential that treatable forms of amyloid be distinguished from those in which effective therapy at present does not exist.

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**Fig 3 — Cross section of the ventricles at the level of the papillary muscles; diffuse amyloid deposition resulting in cardiomegaly (left) and a normal age and sex matched control (right).**



**Fig 4 — Posterior tricuspid leaflet and adjacent atrial endocardium with extensive amyloid deposition resulting in the irregular "honey dewdrop" surface.**

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# A Dancer's Last Dance

**N**ine decades have passed since Martha Graham was born, the daughter of an East Coast physician. After moving to California at a young age, Ms Graham grew up with contrasting environmental signals. Her home was a strict place, with her father's conservative values holding reign. By age 21, however, family could no longer restrain her from her dreamed-about love, dancing. Lessons and experience with the thrill of the performance steeled her will to master her chosen profession and get the center stage. Within a decade Ms Graham was dancing before sophisticated and appreciative crowds, and her future seemed predestined to be rich.

What she gave us, the many generations to follow her, would be a definition of a new style — modern dance. Body movement, starting from the trunk, and at times gyrate, at times serpiginous, then writhing of the extremities, would be paramount for her. Discarding old form for her athletic and expressive style, Ms Graham initiated a whole new dance form.

Not satisfied with changing or modifying what others invented and scored for a performance, she embarked on another career of choreography. With her works performed and popularized, she forced a revolution on both the American and international dance

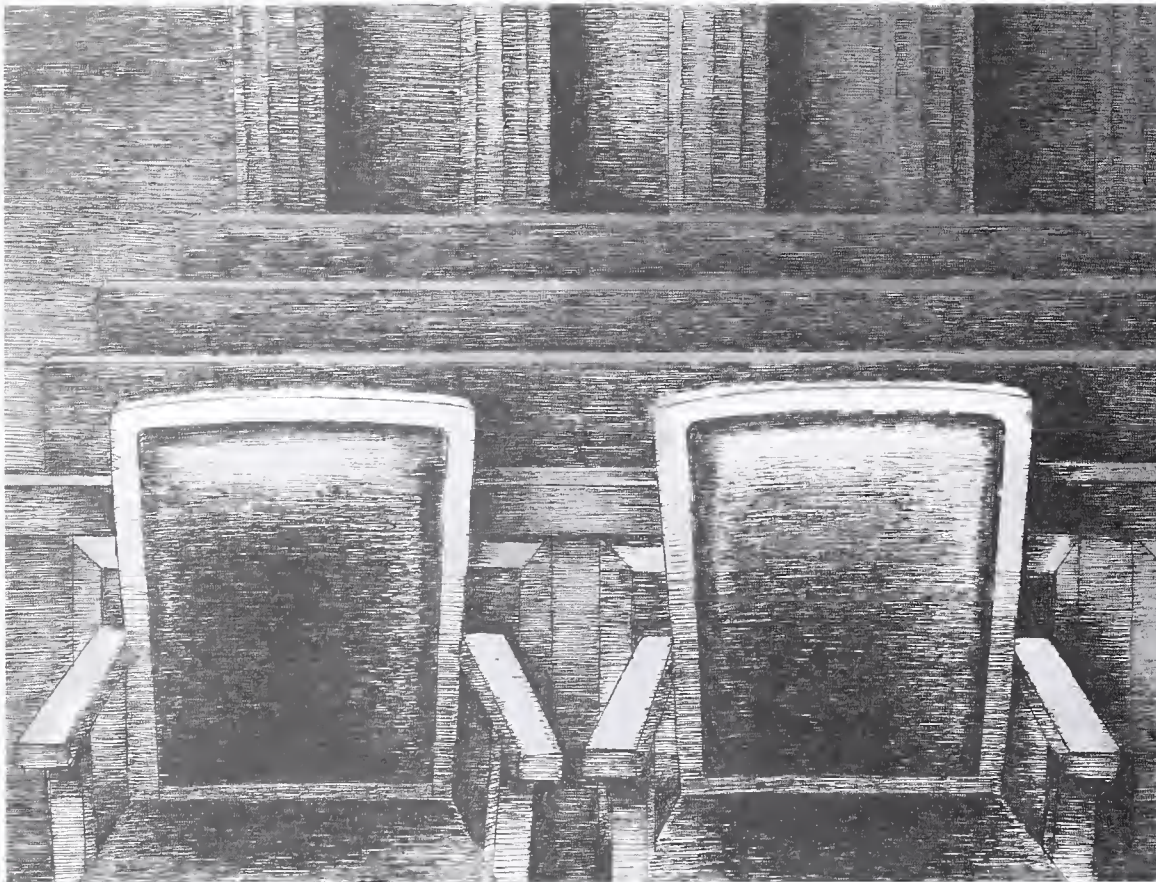
field that is still living out its momentum. She and other performers of her work would give expression to both the dark side — the pathos — and to the light side — the comedy and frivolity.

Her genetics could not be passed directly, but the dance school she founded would populate the next and future generations with her engendered style and form. Taught directly by her, despite decades of different ages, these once and future stars grabbed at her teachings and incorporated as much of her as they could absorb.

To the physician Ms Graham represented the quintessential patient. We encourage healthy activity, athletic and aerobic programs, a life-style that rewards discipline and taking care of one's body. To Ms Graham and to many of us, the body is the temple of the mind. In her temple she worshipped creativity, invention, dynamic thinking. Caring for herself with attention to diet and activity, she was able to use her more than nine decades to the fullest. Her lesson to all of us, to physicians and patients, is to take care and protect what we have from harm. Drugs, inactivity, and regressive thinking may entomb us before our time. Remember Ms Graham and thank her for being so alive.

**Stephen Z. Smith, MD**





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## A Message to Surgeons

**T**O THE EDITOR: Of recent great concern to me as Medical Director, Medicare Part B, has been the necessity to deny reimbursement to a number of surgeons who are non-participating and who have not met the obligation to discuss with patients beforehand their financial obligation following elective surgery. This regulation states that if surgical charges are to amount to more than \$500, there must be a disclosure to the patient ahead of time (except on an emergency basis). This rule has been in effect since 1987 and is effective except in the case of an emergency. It is the writer's opinion the definition of emergency was not precise enough in the 1987 regulations. This view is substantiated by the exceptions that have been claimed by any number of surgeons in the state. This writer felt that the definition was not clear enough and was the cause for some confusion. Accordingly, the writer had received further confirmation from our Regional Office and I quote the following paragraph.

... "We appreciate your concern for Medicare beneficiaries in situations requiring disclosure of the cost of elective surgery by non-participating physicians. We believe your action in denying the claims is proper and supported by the language of OBRA '86, MCM 4360, and most recently an identical letter that was issued on February 20, 1990. In that letter, the Acting Director of HCFA's Office of Program Operations Procedures reaffirmed that, 'an emergency exists where the need for the surgery is so urgent as to afford no alternatives to the physician or patient and, if delayed, could in fact result in death or permanent impairment.' He clarified the definition of emergency further by stating, 'if a patient and the physician had time to schedule the surgery, no emergency exists.' "

Specifically, an emergency exists from the time the patient is first seen by the surgeon until he gets to the operating room that there is essentially no delay. Such cases would be a compound fracture of the

femur, a gunshot wound to the abdomen, or a perforated ulcer. With the hospital course clearly indicating a movement from the first encounter straight on to the operating room. Examples of urgent (but not emergency surgery) would be acute gallbladders, fractured hips, and symptomatic aneurysms which are kept in the hospital from 24 to 48 hours tuning them up for surgery. These cases are considered urgent and not emergencies. There is ample time to talk with the patient, explain to them the operation, and what their financial obligations are.

One hopes the publication of this letter will alleviate some of the disappointments in reimbursement and resulting painful correspondence between the Medical Director and surgeons in the Commonwealth.

The writer would be happy to discuss this via letter or by phone at (606) 281-5837.

**J.B. Holloway, MD**  
**Medicare Part B**  
**Medical Director**

## A Response to Dr Nelson

**T**O THE EDITOR: I read your recent letter "Dr Nelson Responds . . ." in KMA Journal Volume 89, April 1991.

Four of your five proposals for increasing health insurance coverage involve extending government benefits and obligations. In contrast, your cost containment recommendations are not as well developed in conception.

The present budget situation at both the federal and state level precludes funding more coverage for more people. Further, this would

encourage the misconception that medical insurance is something that should be done for the average person as opposed to the view that it is a matter of individual responsibility.

No improvement in the current situation can occur without very significant cost sharing proposals; for instance, 50% co-pay on current Medicare rates. Private insurance should also implement such programs.

This would lead to short-term financial losses for physicians. These

should be made up the way physicians have always made up for financial losses during the last 25 centuries: Physicians must be free to charge without restriction those who have the ability to pay those charges. In other words, the care of the rich should subsidize the care of the poor. Current Medicare regulation actually forbids this practice.

This proposal would also have the virtue of making many administrative cost oversight programs unnecessary. With patients bearing



much more of the burden of their own medical care there would no longer be the necessity for these programs.

In addition, we as a profession must accept the fact that we cannot offer identical medical care to all people. Some people can afford more elaborate medical care than others. This does not mean that people with less money will necessarily get an inferior quality of medical care, only that their medical care will be

different. Having accepted this fact, we can allow physicians to more freely set up insurance plans and proposals for medical insurance for people of lesser means that deliberately exclude very expensive types of services but allow delivery of basic health care. This same consensus would accept the fact that the removal of physician torts from the present court system is absolutely necessary for any kind of meaningful change to occur in the whole system.

Physicians must be free to use their ingenuity to offer low cost and effective medical care to match the budgets and needs of differing patient groups. They must accept the fact that everybody cannot have the same medical care. This does not mean however that their medical care is in any way inferior.

**F. Andrew Morfesis, MD**



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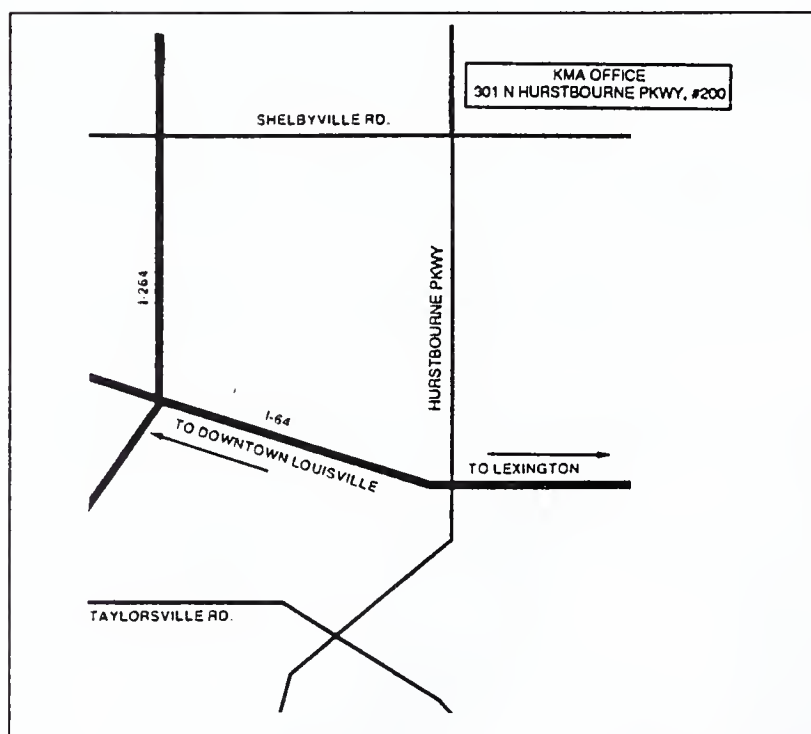
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## AKMA *Connections*

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***“All KMA members are asked to encourage their spouses to be a part of the Auxiliary Connection — to become a member of the Auxiliary to the Kentucky Medical Association.”***

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The Auxiliary to the KMA is a volunteer organization composed of spouses of members of the KMA. The purposes of the organization include supporting the activities of the KMA, providing training and services to our members, and serving as a support group. The members of the AKMA are members of a federation of county, state, and national volunteer organizations with a membership of over 70,000.

The AKMA serves as a coordinating group to provide communication and service between the county and national auxiliaries. As Auxiliary members, we serve as advocates for medicine and the medical profession. We promote health and healthy lifestyles in our communities by providing services to our communities through health projects.

Medical Student Spouse and Resident Physician Spouse Groups are organized at the medical training centers throughout this state. The AKMA is active in sponsoring and

supporting these groups which promote the involvement of the physician spouse.

The Auxiliary also supports medical education and research. Through AKMA, auxiliaries across the state donated over \$70,000 to provide funds for medical student assistance through the American Medical Association-Education Research Foundation (AMA-ERF).

Financial assistance is provided by the AKMA to Kentucky residents pursuing careers in health-related fields through the Auxiliary Health Careers Fund. Although funds are limited through this scholarship program, needy students are assisted every year through monies donated by Auxiliary members.

Training, networking, and support for medicine are all primary goals of the Auxiliary to the Kentucky Medical Association. Legislative issues, support of medical education, assistance for students and their spouses, and health projects are some areas of concern and involvement by



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***“The opportunities provided for the physician spouse through Auxiliary membership are varied. One major asset is the connection provided to other physician spouses. The chance to network with others who have a common goal — an interest in and a commitment to medicine.”***

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the State Auxiliary and its component county auxiliaries.

The opportunities provided for the physician spouse through Auxiliary membership are varied. One major asset is the connection provided to other physician spouses. The chance to network with others who have a common goal — an interest in and a commitment to medicine. Membership in Auxiliary, whether as an active participant or a dues paying supporter of Auxiliary programs, is important to the future of the medical family.

All KMA members are asked to encourage their spouses to be a part of the Auxiliary Connection — to become a member of the Auxiliary to the Kentucky Medical Association. Whether as a member of an organized county auxiliary or as a member-at-large, the Auxiliary tries to meet member needs. The physician spouse, the professional spouse, the male spouse, the office spouse, the international spouse, and the at-home spouse are all vital components of the Auxiliary. The Auxiliary to the KMA and the AMA Auxiliary are making every attempt to provide services for all aspects of the medical family.

Information on becoming a member of the Auxiliary to the KMA is available by contacting:

Jean Wayne  
AKMA Executive Secretary  
3532 Ephraim McDowell Dr  
Louisville, KY 40205



**AKMA President**

## JULY

**31-August 4 — Southern Association for Oncology 4th Annual Meeting**, Crystal Palace Resort and Casino, Nassau, Bahamas. Contact: Southern Association for Oncology, 205/942-0530; or SMA Travel, 800/423-4992.

## AUGUST

**7-11 — Southern Orthopaedic Association 8th Annual Meeting**, The Broadmoor, Colorado Springs, CO. Contact: Southern Orthopaedic Association, 205/945-1848.

## SEPTEMBER

**14 — Lasers and Beyond**, presented by N. D. Radtke, MD, and Humana Hospital Audubon. Category I credit. Contact: N. D. Radtke, MD, 240 Audubon Medical Plaza, Louisville, KY 40217; 502/636-2823.

**20 — Clinical Update for Ophthalmic Nurses and Technicians**, Radisson Plaza Hotel, Lexington, KY. Contact: Kay Montgomery, The Center for Advanced Eye Surgery, Humana Hospital-Lexington, 150 N Eagle Creek Dr, Lexington, KY 40509; 606/268-3754.

**20-21 — Clinical Advances in Cataract, Glaucoma and Corneal Surgery**, Humana Hospital-Lexington. Contact: Kay Montgomery, The Center for Advanced Eye Surgery, Humana Hospital-Lexington, 150 N Eagle Creek Dr, Lexington, KY 40509; 606/268-3754.

**21 — Corneal-Contact Lens Update 1991**, Radisson Plaza Hotel, Lexington, KY. Contact: Kay Montgomery, The Center for Advanced Eye Surgery, Humana Hospital-Lexington, 150 N Eagle Creek Dr, Lexington, KY 40509; 606/268-3754.

## OCTOBER

**11 — Practical Diabetes Management Symposium for the Primary Care Phy-**

**sician**, Marriott Griffin Gate Resort, Lexington. Presented by The Diabetes Center of Excellence at Humana Hospital, Lexington. Contact: Kay Montgomery, Humana Hospital-Lexington, 150 N Eagle Creek Dr, Lexington, KY 40509; 606/268-3754.

**27-November 1 — Twenty-Second Family Medicine Review — Session III**; Hyatt Regency Hotel, Lexington, KY. Contact: Ms Joy Greene, Director CME, 132 College of Medicine Office Bldg, U of K, Lexington, KY 40503-0086; 606/233-5161.

## NOVEMBER

**4-8 — 57th Annual Scientific Assembly of the American College of Chest Physicians**, San Francisco Marriott and the Moscone Center, San Francisco, CA. Contact after June 20, 1991: American College of Chest Physicians, Division of Education, 3300 Dundee Rd, Northbrook, IL 60062-2348; 708/498-1400.

**16-19 — Southern Medical Association's Annual Scientific Assembly**, Georgia World Congress Center and Atlanta Hilton and Towers, Atlanta, GA. Contact: SMA, 800/423-4992.

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The American Cancer Society, sponsor of the Food Fight, has more information. Call **1-800-ACS-2345**.

And, be on the lookout for Community Crusade volunteers armed with shopping lists.



Public Service Message



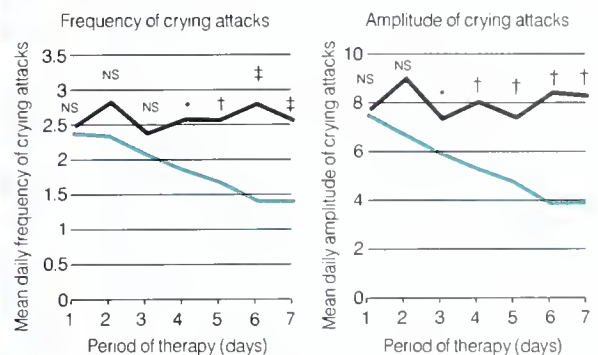
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1. Kanwaljit SS, Jasbir KS. Simethicone in the management of infant colic. *Practitioner*. 1988;232:508

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**Pendleton**  
Moreland Drug

**Perry**  
L. B. Clinic Pharmacy  
SuperX Drugs  
Vicco Pharmacy

**Pike**  
Medical Pharmacy  
Nichols Apathecery  
SuperX Drugs

**Pulaski**  
Brown's Bogle Street Pharmacy  
Kroger Company  
Somerset Pharmacy  
SuperX Drugs  
The Medicine Shoppe  
Tibbals Drug Store  
Wal-Mart Pharmacy

**Rockcastle**  
Mt. Vernan Drive-Thru  
Youngs Pharmacy

**Rowan**  
Cave Run Pharmacy

**Russell**  
Daugherty Pharmacy  
Hopper Drug

**Scott**  
Dactar's Park Pharmacy  
Fitch Drug Store  
Kroger Company

**Shelby**  
Smith-McKenney

**Simpson**  
Arnold Drug Company  
Prescription Shop  
R. H. Maare Drug Company  
Shugart & Willis

**Spencer**  
W. T. Froman Drug Company

**Taylor**  
Central Drug Center  
Kroger Company  
SuperX Drugs  
The Medicine Shoppe

**Todd**  
Weathers Drugs

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**Union**  
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Sturgis Pharmacy

**Warren**  
Ashley Circle Pharmacy  
C. D. S. #10 Drug  
Clinic Pharmacy  
Medicine Shoppe  
Northgate Pharmacy  
SuperX Drugs  
Taylor Drugs  
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**Washington**  
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# Prevention:



## Rx for Health Care in the 90s

*KMA Annual Meeting · Sept 29 - Oct 3*

*Hyatt Regency Hotel · Lexington, KY*

### Scientific Sessions

The Hyatt Regency Lexington and Lexington Center will host the 1991 Annual Meeting. The Scientific Program Committee has invited speakers from across the nation to participate in the sessions to be held during the mornings of October 1, 2, and 3.

### Specialty Groups

Programs for 23 specialty groups will be held during the afternoons of October 1, 2, and 3. No general sessions are scheduled during the specialty group meetings and all KMA members are invited. Scientific sessions and specialty group meetings will be held in the Lexington Center. By completing CME sign-up sheets at the beginning of each meeting, physicians attending general sessions and specialty group meetings will qualify for Category 1 Credit.

### KMA House of Delegates

The opening meeting of the House of Delegates will be held Monday, September 30, at 9 AM in the Regency Ballroom located in the Hyatt Regency Hotel. Reference committee meetings will begin at 1:30 PM on Monday and the final meeting of the House will begin at 7 PM Wednesday, October 2. Officers for the 1991-92 Associational year will be elected during the final House meeting.

### Other Activities

The 29th Annual KEMPAC Seminar will be held Monday evening, September 30, in the Patterson Ballroom, located in the Hyatt Regency Hotel. A reception begins at 6 PM with dinner at 7 PM, and the program to follow at 8 PM.

The President's Luncheon will be held October 2 with presentations of KMA awards and the installation of the 1991-92 KMA President, S. Randolph Scheen, MD.

Scientific and Technical Exhibits will be on display featuring new medical products, services, and techniques. Members and guests have an opportunity to visit this area during the 30-minute intermissions scheduled throughout the general sessions and specialty group meetings.

This month's article will feature some of the historical landmarks located in or near Lexington.

### ASHLAND, The Henry Clay

**Estate** — East of the downtown area, this lovely restored residence was the home of Henry Clay, an 18th century statesman and three-time Presidential candidate. Surrounded by 20 acres of expansive woodland, Ashland, a National Historic Landmark, is furnished throughout with Clay family possessions and furniture. Four generations of the Clay family have been associated with the property, from 1806 when Henry Clay purchased the farm, until 1948.

### HOPEMONT, The Hunt-Morgan

**House** — Built in 1814 by millionaire John Wesley Hunt, this Federal style townhouse is associated with the Hunt and Morgan families — most notably Confederate General John Hunt Morgan, the "Thunderbolt of the Confederacy," and Nobel Prize Winner, Dr Thomas Hunt Morgan.

Located in Gratz Park, Fayette County's oldest historic district, the house boasts a collection of fine

Kentucky furniture, early 19th century portraits and porcelains. Architectural features of the house include a three-story cantilevered staircase, a walled courtyard, and a garden.

### MARY TODD LINCOLN HOUSE —

Built in 1803, the Mary Todd Lincoln House, located on Main Street, is the first shrine to a first lady in America. In these surroundings, Mary Todd spent her girlhood, completed 13 years of formal education, and in 1839, left to visit her sister in Springfield, Illinois, where she met Abraham Lincoln.

### WAVELAND STATE HISTORIC SITE —

A tour of historic homes would not be complete without visiting the Waveland State Historic Site, located at 225 Higbee Mill Road. Exemplifying a true antebellum home, Waveland was built in 1847 by Joseph Bryan, a grand nephew of Daniel Boone. The grounds boast an impressive array of nineteenth century dependencies, including brick servants' quarters, an ice house, and a smokehouse.

### THE LEXINGTON CEMETERY —

Chartered in 1848, this historic cemetery is known as one of the most beautiful cemeteries in America. Located on West Main Street, the beautifully landscaped grounds highlight two lakes with water fowl and goldfish, a sunken garden, and other gardens. Some notables buried in the cemetery include Henry Clay, General John Hunt Morgan, Adolph Rupp, Vice President John C. Breckinridge, and Author James Lane Allen.

### TRANSYLVANIA UNIVERSITY —

Located near Gratz Park is Transylvania University, where the stately columns of Old Morrison are a striking example of Greek Revival architecture. Old Morrison, designed by the famous architect Gideon Shyrock in the early 1800s, was the first building on campus and served as both a prison and hospital to the North and South armies during the Civil War.

Much of historic Lexington is legendary while some of the past is still being delightfully discovered. *kma*

*Mary Todd Lincoln House*



America's Best of Show:  
*Lexington*  
KENTUCKY



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## PEOPLE

City of Paducah Mayor and AKMA past president **Gerry Montgomery**, wife of KMA past president **Wally O. Montgomery, MD**, was recently

awarded an Honorary Doctor of Law degree from her alma mater, Georgetown College in Georgetown, Kentucky. A 1959 graduate of the college, Mrs Montgomery serves as a member of a select group of individuals known as the Georgetown College Associates. Dr Wally Montgomery and two of the three Montgomery children are also graduates of Georgetown. Daughter Kathy Montgomery is an interior designer and daughter **Evelyn M. Jones, MD**, is a dermatology resident at the University of Louisville. Son Steve, a graduate of Centre College in Danville, is a student at the U of L School of Medicine.

**Dr Norman D. Radtke**, Chairman of the American Diabetes Association, Kentucky Affiliate, and Chairman of their Research Committee, recently announced that seven Kentuckians were awarded research grants by the ADA. Dr Radtke emphasized that continued excellence in research and the traditions of the American Diabetes Association were key factors in the selection of the projects. Included among the recipients were KMA member physicians **Robert W. Prasaad Steiner**, **Gabriel Smilkstein**, and **T. Jeffrey Wieman**.

**Dr Michael D. Hagen**, Associate Chairman, Department of Family Practice of the Albert B. Chandler Medical Center, University of Kentucky, was recently appointed to serve a 5-year term on the American Board of Family Practice.

The following KMA member physicians were included in recent U of L School of Medicine appointments: **Randy Buckspan**,

clinical instructor, surgery; **James Crews**, **Don Perkins**, **George Shpilberg**, and **Dewey Wood** assistant clinical professors, family practice; **Dan Miller**, assistant clinical professor, medicine; **Theodore Wandzilak**, clinical instructor, ophthalmology and visual sciences; **Dewey Wood**, clinical instructor, family practice; **Thomas Dedman**, assistant clinical professor, surgery; **Richard Mitchell** and **William Mitchell**, assistant clinical professors of surgery; and **Robert Dockery**, emeritus assistant clinical professor, ophthalmology and visual sciences.

**Richard F. Hench, MD**, Lexington internist, succeeded the retiring **Ballard W. Cassady, MD**, as Chairman of the Board of Directors of the Kentucky Medical Insurance Company. Dr Hench is a former KMA Trustee, Chairman of the Board of Trustees, and 1986-87 President of KMA.

Cassady was named by the KMA Board of Trustees in 1978 to serve as the first Chairman of KMA's Insurance Agency, forerunner of the Kentucky Medical Insurance Company. He was subsequently elected Chairman of the Board of KMIC at its initial meeting and served as Chairman until April, 1991.

Both Dr Cassady and Dr Hench are recipients of KMA's highest award, the Distinguished Service Award.

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## UPDATES

### *Journal Wins an Award*

For the first time, the *Journal of the Kentucky Medical Association* has won an award in the Sandoz Medical Journalism Awards. The *Journal* was recognized for excellence in design and editorial content.

Judges for this 16th annual Sandoz competition were

professionals of national reputation in the publishing field. Awards were presented in five categories — state medical associations, local medical publications, state pharmaceutical associations, hospitals, and newsletters. Entries were evaluated on criteria such as layout, typography, photography, and production.

Part of a continuing program conducted by Sandoz Pharmaceuticals to encourage superior medical editing and writing, the awards attract entries from all over the country.

One judge, Paul Fisher, recently retired journalism professor at the University of Missouri, used these comments in describing the KMA *Journal*. "It has a very certain, very assured style. The word we might use for it is elegant. Nothing blatant. It is simple and at the same time, distinctive, and when you can meld these two together, being simple and being distinctive, then of course, you have a piece of work on your hands. Graphically, the Kentucky *Journal* is ranking up with the very best that are entered in this division."

Heart of the Sandoz program is a series of annual teaching workshops, at which medical editors can learn from experts how to enhance both graphics and text of their publications.

**A. Evan Overstreet, MD**, is editor of the KMA *Journal*.

### KMA Receives Certificate of Excellence

The Kentucky Medical Association has been chosen as one of 47 Certificate of Excellence winners in the American Society of Association Executives (ASAE) Advance America Awards Program.

The awards will be presented at the ASAE Annual Meeting ceremonies scheduled for Wednesday, August 14, 1991, in Washington, DC.

In a letter from R. William Taylor, ASAE President, it was noted that "Your Kentucky Physicians Care program truly embodies the spirit of the Association's Advance America campaign — to showcase the many things associations are doing to make this country a better place in which to live.

"Our warmest congratulations on receiving this honor. As President Bush has said, 'There is no problem in America that is not being solved somewhere.' You have shown that this is especially true among associations."

### Diabetics Needed for Research

Diabetic adults who are not dependent on insulin are needed for a U of L study to be conducted by researchers in the Department of Diabetes and Endocrinology. Research volunteers must be patients who have failed to respond to diets and drugs to control their diabetes.

Researcher **Vasti Broadstone, MD**, says the study will compare a new drug with an oral drug already on the market. The 12-month project will provide all participants with equipment to monitor their blood sugar. For more information, call Eloise Campbell 502/588-5237.

### FDA Approves FLOXIN® (ofloxacin)

FLOXIN® (ofloxacin), a potent broad-spectrum oral antibiotic, co-marketed by Ortho Pharmaceutical Corporation and McNeil Pharmaceutical, two Johnson & Johnson subsidiaries, is now available for use against many common infections. One of a new class of antibiotics called quinolones, FLOXIN was recently approved for marketing by the US Food and Drug Administration. The medication treats many common infections such as lower respiratory tract, urinary tract, prostate (chronic bacterial prostatitis due to *E. coli*), moderate to mild skin

and soft tissue infections, and sexually transmitted diseases (chlamydia and gonorrhea).

### National Toll-Free Helpline Provides Medical Eye Care to Elderly Americans

More than 164,000 needy elderly have been referred to volunteer ophthalmologists in their communities since the inception of the National Eye Care Project 5 years ago. Nationwide, more than a quarter-million people have called the Helpline for assistance.

The toll-free Helpline of the National Eye Care Project: **1-800-222-EYES** (1-800-222-3937) is an information and referral service, providing brochures on many common eye diseases of the elderly and for eligible callers, a referral to a local volunteer ophthalmologist.

For this program, the physician has agreed to provide a comprehensive medical eye examination and care for any condition diagnosed, at no out-of-pocket expense to the patient.

To qualify for a referral, the patient must be a US citizen or legal resident, 65 or older, who does not have access to an ophthalmologist he or she has seen in the past. This is not an eyeglasses program, and prescription drugs or hospital care are not covered.

The Helpline operates weekdays, 8 am to 4 pm Pacific time.

### Enzyme Replacement Therapy Gives Hope to Gaucher's Patients

An enzyme replacement therapy used at the University of Louisville offers new hope to victims of Gaucher's disease.

Victims of the rare disorder can't produce an enzyme that disposes of fatty substances known as lipids. As a result, lipids accumulate in the

spleen, liver and bone marrow, preventing them from functioning properly.

Pediatric oncologist **Salvatore Bertolone, MD**, replaces the enzymes with a drug called Ceredase. The new method, which received FDA approval in April, may replace spleen removal and bone marrow transplantation as the treatment of choice.

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## AMA BRIEFS

### Smoking Ban Urged

In a letter to the White House, Executive Vice President James S. Todd, MD, urged President Bush to sign a pending executive order to prohibit smoking in federal office buildings. In a related matter, Dr Todd informed the Department of Veterans Affairs of a House of Delegates resolution against the sale and use of tobacco products in Veterans Administration hospitals. Dr Todd noted that 39 states have enacted laws that restrict smoking in health care facilities.

### Guidelines Drafted for MD Advertising

The AMA is working with several specialty groups to develop guidelines for truthfully advertising physician services. The Federal Trade Commission is reviewing the AMA's draft set of directives, which will be available for general release this summer. While not intended to be a statement on the ethics of professional advertising, the guidelines build upon the principle that physicians may not engage in advertising that is false, misleading or deceptive. The goal of the AMA effort is to obviate the need for proposed state legislation. The guidelines are the work of the AMA, the American



Academy of Facial Plastic and Reconstructive Surgery, the American Academy of Dermatology, the American Academy of Dermatologic Surgery, the American Academy of Otolaryngology-Head and Neck Surgery, and the American Society of Plastic and Reconstructive Surgeons.

### AMA Groups Visit Capitol Hill

Federation groups from across the country continue to schedule visits to the nation's capital for meetings with their congressional delegations and other federal officials. The Washington Office hosted Capitol Hill visits for the Medical Students Section governing council in May, and for the Kentucky and Tennessee state medical associations in June.

### Display your Certificate

A survey showed that 85% of the public believe that their physician should be an AMA member. For that reason, the Division of Membership is encouraging physicians to display their membership certificates as a pledge of high ethical standards. With each certificate it mails to members, the division is including a form to order a handmade walnut frame embossed with the AMA signature.

## NEW MEMBERS

*Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.*

### Fayette

**H. Spencer Turner, MD** — PM  
UMKC — B 165, Lexington 40536  
1963, Ohio State

### Hardin

**Ted H. Moore, MD** — S  
914 N Dixie, Elizabethtown 42701  
1984, U of Kentucky  
**Jeffrey B. Richardson, MD** — D  
1306 Morton Ave, Louisville 40204  
1987, U of Louisville

### Jefferson

**Thomas E. McCormick, MD** — PD  
3718 Bristol Oaks Dr, Louisville 40299  
1987, U of Louisville  
**Kathleen A. Sheerin, MD** — A  
1105 Rostrevor Cir, Louisville 40205  
1983, Duke U School of Medicine

### Letcher

**John Palmer Lanier, MD** — OBG  
PO Box 954, Whitesburg 41858  
1981, Medical College of Georgia

### Northern Kentucky

**Brett B. Coldiron, MD** — D  
1938 Mt Vernon, Fort Wright 41011  
1982, U of Kentucky

### Perry

**Frank D. Mongiardo, MD** — OTO  
PO Box 230, Bulan 41722  
1986, U of Kentucky

### Pulaski

**Amr O. El-Naggar, MD** — NS  
110 Hardin Ln #1, Somerset 42501  
1977, Ain Shams U, Egypt

### New In-Training

### Fayette

**Ricky L. Angel, MD** — FP  
**Renee V. Girdler, MD** — FP  
**Katherine J. Miller, MD** — FP  
**Whitaker M. Smith, MD** — FP

### Jefferson

**Alan J. Cox, MD** — IM  
**Franco R. Rea, MD** — TS  
**Elizabeth B. Shelton, MD** — P  
**Barbara M. Talwar, MD** — AN  
**Eileen M. Walsh, MD** — PD  
**Joseph W. Wilson, MD** — TS

## DEATHS

**Cordell H. Williams, MD**  
**Hazard**  
**1914-1991**

Cordell H. Williams, MD, a retired internal medicine physician, died February 28, 1991. Dr Williams graduated from the University of Tennessee College of Medicine in 1944 and was a life member of KMA.

**William R. McCormack, MD**  
**Bowling Green**  
**1911-1991**

William R. McCormack, MD, a retired general practitioner, died May 1, 1991. Dr McCormack graduated from the University of Louisville School of Medicine in 1937 and was a life member of KMA.

**Waitman B. Taylor, MD**  
**Owensboro**  
**1955-1991**

Waitman B. Taylor, MD, an internal medicine physician, died May 4, 1991. Dr Taylor was a 1983 graduate of the University of Louisville School of Medicine and an active member of KMA.

**Chalmer D. Phelps, DMD**  
**Clarksville, IN**  
**1904-1991**

Chalmer D. Phelps, DMD, a retired dentist, died May 5, 1991. Dr Phelps was an associate member of KMA.

**Edward L. Callahan, MD**  
**Louisville**  
**1934-1991**

Edward L. Callahan, MD, a pathologist, died May 10, 1991. A 1960 graduate of the University of Louisville School of Medicine, Dr Callahan was an active member of KMA.

**Abner Golden, MD**  
**Lexington**  
**1922-1991**

Abner Golden, MD, a professor and former chairman of the University of Kentucky College of Medicine pathology department, died May 28, 1991. A 1942 graduate of Harvard Medical School, he was instrumental in establishing a clinic for indigent patients sponsored by the Lexington-Fayette County Health Department and UK College of Medicine, and was responsible for the establishment of a free clinic based at the Lexington Salvation Army. In 1985 he received the first UK College of Medicine Dean's Recognition Award for contributions to his field. Dr Golden was a life member of KMA.

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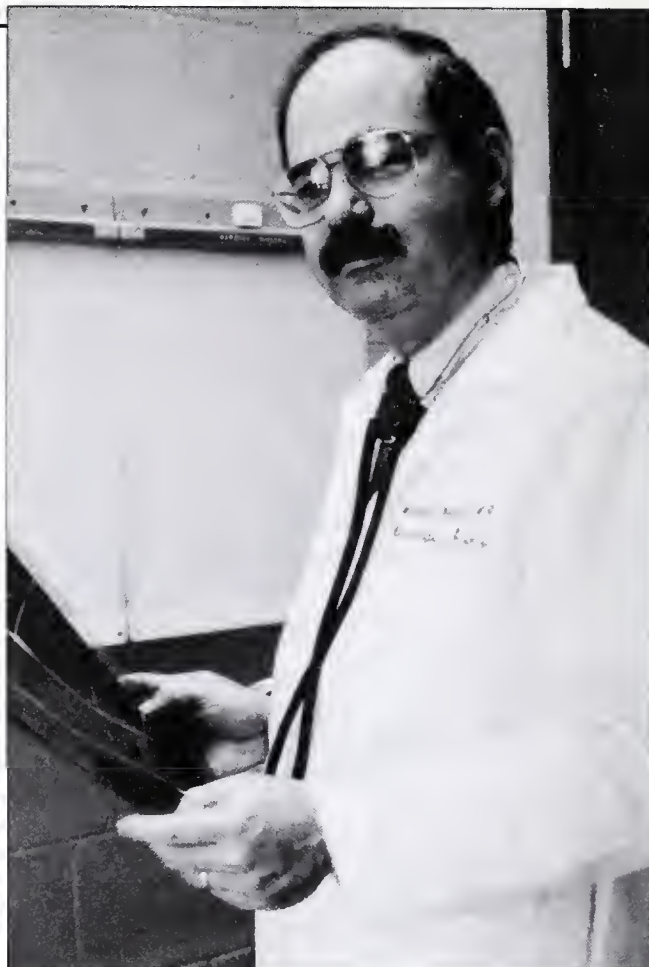
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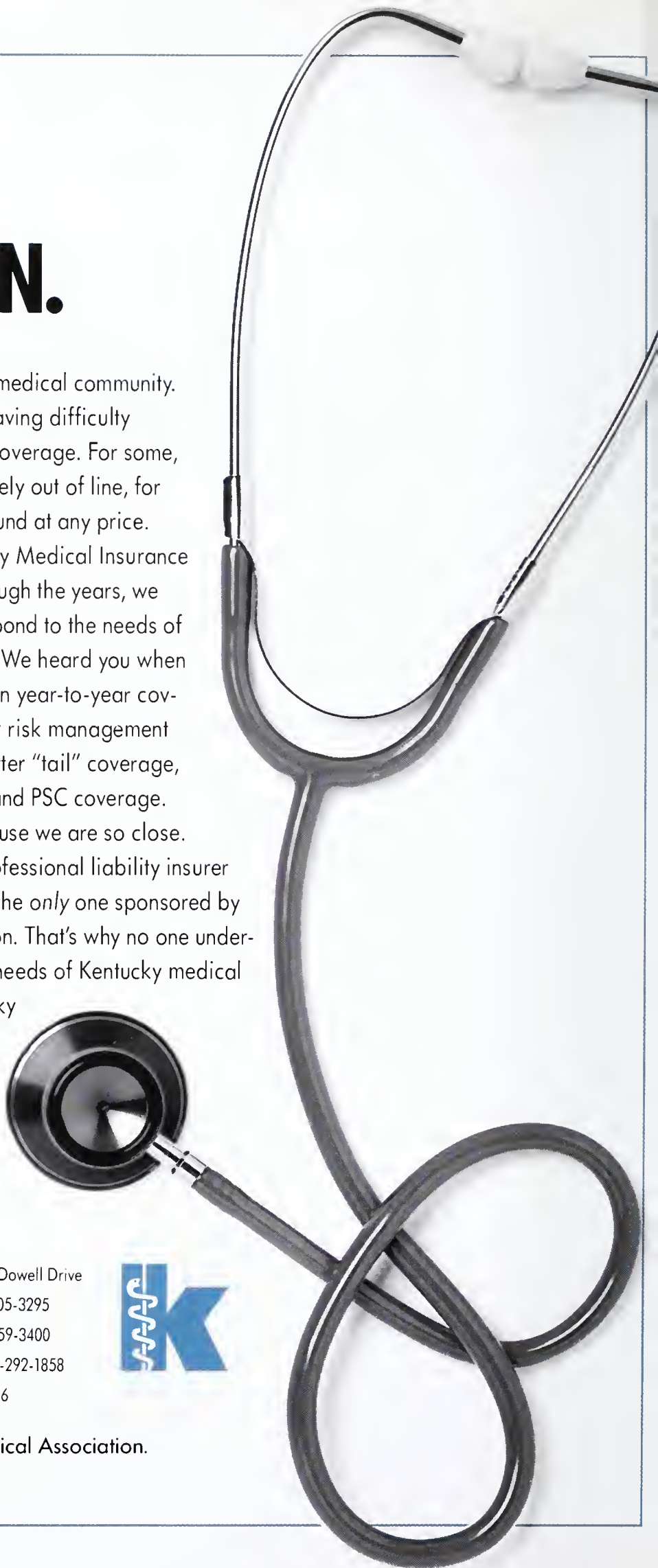
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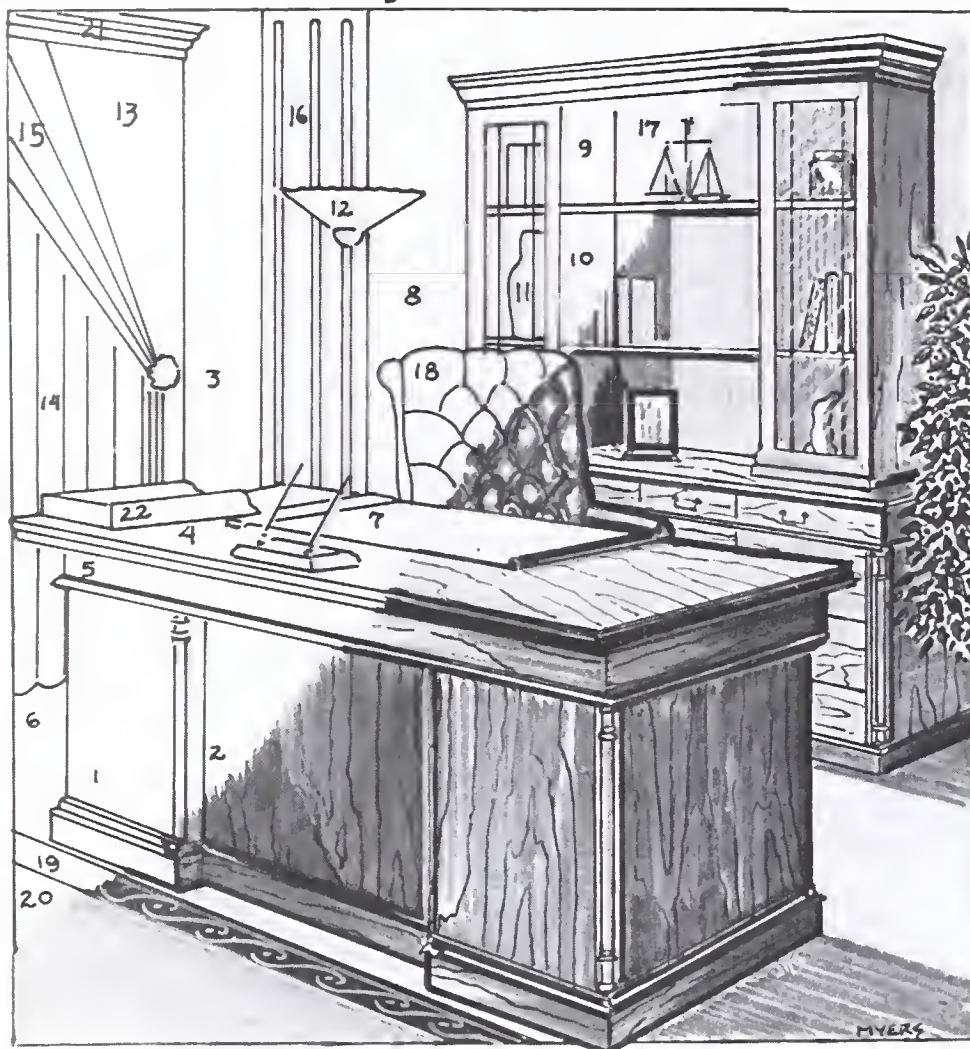
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VOLUME 89, NUMBER 8

AUGUST 1991

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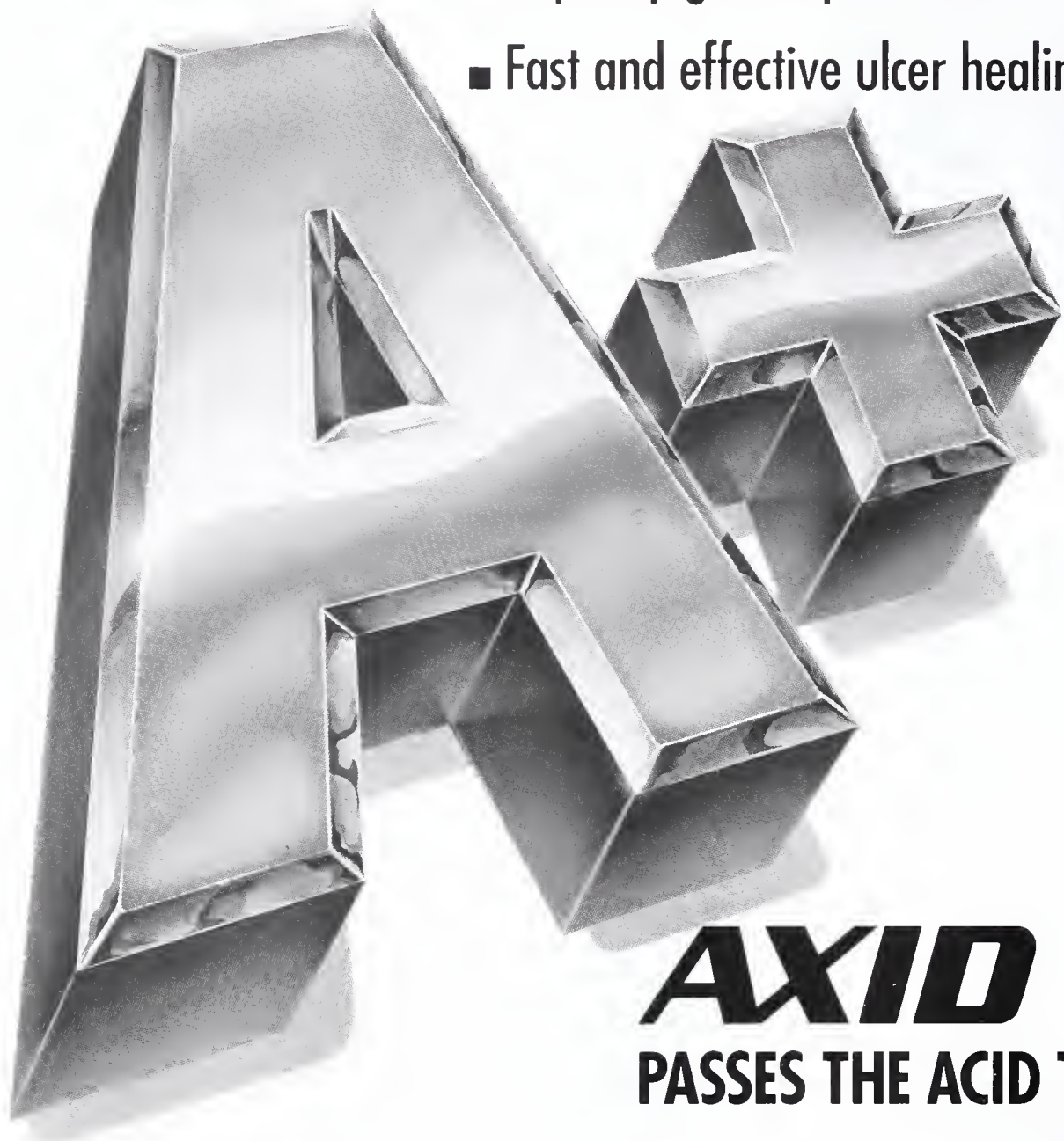
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**Carcinogenesis, Mutagenesis, Impairment of Fertility**—A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

**Pregnancy—Teratogenic Effects—Pregnancy Category C**—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect, but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

**Nursing Mothers**—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

**Pediatric Use**—Safety and effectiveness in children have not been established.

**Use in Elderly Patients**—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

**Adverse Reactions:** Clinical trials of varying durations included almost 5,000 patients. Among the more common adverse events in domestic placebo-controlled trials of over 1,900 nizatidine patients and over 1,300 on placebo, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common with nizatidine. It was not possible to determine whether a variety of less common events were due to the drug.

**Hepatic**—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

**Cardiovascular**—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

**CNS**—Rare cases of reversible mental confusion have been reported.

**Endocrine**—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to nizatidine. Impotence and decreased libido were reported with equal frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

**Hematologic**—Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H<sub>2</sub>-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

**Integumental**—Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

**Hypersensitivity**—As with other H<sub>2</sub>-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

**Other**—Hyperurcemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

**Overdosage:** Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis does not substantially increase clearance of nizatidine due to its large volume of distribution.

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# Upper Extremity Wound Management: Intermediate Infections

Lorne E. Weeks, III, MD; Luis R. Scheker, MD

From the Christine M. Kleinert Institute for Hand and Micro Surgery, Louisville, KY, and the Division of Orthopaedic Surgery, University of Kentucky College of Medicine, Lexington, KY.

*A careful history and physical examination, including information regarding position of the hand at the time of injury, presence of other disease, handedness, age, and occupation, are all essential to evaluate hand infection. If surgery is anticipated, antibiotics should generally be withheld until operative cultures are obtained. Infections secondary to human bite injuries are common and are usually caused by a blow of the fist to the mouth. These injuries can produce crippling sequelae, must be managed promptly and aggressively, and often require surgery. Flexor tenosynovitis, often caused by a penetrating injury, may be treated nonoperatively if the patient presents within 24 to 48 hours of onset. Older injuries always require incision and drainage of the flexor tendon sheath. Most authors agree that surgical management of dog bite wounds to the hand is essential. Cat and arthropod bites may also require surgery.*

## General Principles

A careful history and physical examination are essential to evaluate hand infection. The position of the hand at the time of injury is important to establish the level of injury to tendons and potential for joint involvement. Also, some occupations increase the risk of particular infections, such as the association of herpetic whitlow infections in dental hygienists and *Mycobacterium marinum* infections in fishermen.<sup>1</sup> Likewise, the presence of immunologic compromise caused by diseases such as diabetes mellitus and AIDS places the patient at increased risk. On physical examination, the exact location of tenderness and the presence of fluctuance, lymphangitis, or lymphadenopathy need to be documented. Any joint stiffness or swelling should be recorded.

Laboratory tests should include CBC with differential, erythrocyte sedimentation rate, cultures

(aerobic and anaerobic) and sensitivity of any drainage, and fungal cultures, which may take up to 30 days. AP and lateral radiographs of the involved hand must be obtained as well.

At the time of surgery, a tourniquet is desirable, but exsanguination with an Esmarch-Martin bandage should be avoided to prevent systemic dissemination of bacteria. Since bacteria proliferate most readily in dead and devitalized tissue, a thorough debridement back to vascularized margins is obligatory. Regional or general anesthesia is necessary, as local anesthesia instilled within cellulitic tissue is harmful.

Antibiotics should be withheld until operative cultures are obtained. For most infections outside the farm, a cephalosporin or penicillinase-resistant penicillin is appropriate. Exposure to domestic animals or human saliva requires the addition of penicillin. In rural settings, wounds may be contaminated with soil containing gram negative rods. Therefore, an aminoglycoside should be added to the penicillin and penicillinase-resistant penicillin. For those patients allergic to penicillin, clindamycin, vancomycin, or erythromycin with or without rifampin should provide adequate anti-staphylococcal coverage. Antibiotics are adjunctive to thorough debridement and in no way constitute definitive management.

## Clenched Fist Injuries

Complications from relatively common human bite injuries can be more serious than those caused by animal bites (Fig 1). Clenched fist injuries are common and can produce devastating and crippling sequelae. The symbiotic organisms of the human mouth can become virulent and pathogenic when implanted into a suitable environment such as the closed space overlying the metacarpophalangeal (MP) joint.

The most common mechanism involves a fist fight in which the victim's tooth penetrates the skin, most commonly over the second or third



**Fig 1 — (A) Typical clenched fist injury with wound overlying metacarpophalangeal (MP) joint of ring finger and spontaneous drainage. (B) Surgical debridement revealed expected involvement of MP joint with injury to articular cartilage of metacarpal head. (Courtesy of James M. Kleinert, MD)**

MP joint of the right hand. The peak incidence of this type of injury is in warm weather, especially on weekends.<sup>2</sup> The blow is usually delivered with the dominant hand in a clenched position with skin and extensor tendon advanced distally over the flexed MP joint. The articular cartilage of the metacarpal head is almost always injured, and fracture of the metacarpal neck or head may occur as well. When the involved digits are subsequently extended, a subfascial tunnel is created concealing defects in the joint capsule. A perfect medium for bacterial proliferation is thereby generated. The patient, usually an inebriated young male, does not seek medical attention until infection is well established. By 1 or 2 days, pain and swelling have developed. The area around the wound becomes hot, red, tender, and swollen. Associated lymphangitis, cellulitis, and axillary adenopathy may occur. The mobility of the involved digit is severely compromised secondary to pain and swelling. Purulent discharge is noted from the wound, and the patient may be febrile.<sup>3</sup>

The subcutaneous tissue of the dorsum of the hand is loose and ideally suited for transmitting infection, unlike the superficial subcutaneous tissue of the fingers, whose fibrofatty sep-

tae limit the spread of infection at that level. Once established, these infections extend proximally and invade deeper and more vital structures, such as the fascial sheaths and compartments of the hand. Proximal extension along the lumbrical canal into the palm may inoculate the middle palmar and thenar spaces. Infection may also spread distally along the proximal phalanx in the subtendinous space with subsequent development of periostitis and osteomyelitis. Pyogenic arthritis of the MP joint may also develop.

Treatment of clenched fist injuries begins with tetanus prophylaxis. A VDRL or other syphilis screening test should also be performed. Gram stain and aerobic and anaerobic cultures of any drainage are noted. The variety of organisms found in human saliva are introduced into the wound. Common aerobic organisms include alpha- and beta-hemolytic streptococci, *Staphylococcus aureus*, *Staphylococcus epidermidis*, *Eikenella corrodens*, and *Neisseria* species.<sup>4</sup> Anaerobic organisms include *Bacteroides*, *Fusobacterium*, *Peptococcus*, and *Veillonella*.<sup>5</sup>

Mention should be made of the virulent role played by anaerobic organisms such as *Eikenella* in human bite wounds to the hand. *Eikenella*,



## Upper Extremity Wound Management

isolated from wounds contaminated by human saliva, is frequently found in clenched fist injuries and grows best in a medium enhanced with 5% CO<sub>2</sub>. *Eikenella* is sensitive to penicillin, ampicillin, tetracycline and carbenicillin. Most cephalosporins, aminoglycosides, and penicillinase-resistant penicillins are ineffective against *Eikenella corrodens*. Rayan et al<sup>6</sup> suggest that immediate use of a second or third generation cephalosporin only is sufficient to cover most gram-positive and gram-negative organisms, anaerobes and *Eikenella corrodens*.

Initial antibiotic therapy must be empiric pending wound culture and sensitivities and should be directed against penicillinase-resistant *S. aureus*. Once cultures and sensitivities are known, the patient can be switched to a specific agent. Depending upon the severity of the infection, intravenous, oral or a combination of the two modes of antibiotic administration may be used for a 14 to 20 day period.

Among the host of organisms involved, *S. aureus* (a gram positive coccus) is the most commonly involved organism in human bite wounds to the hand and is unfortunately associated with the development of most serious sequelae as well.<sup>7</sup> Eaton and Butsch<sup>8</sup> found that gram positive organisms outnumbered gram negative organisms by 3 to 1 and that 64% of *S. aureus*-infected bites to the hand were penicillin resistant. Therefore, a penicillinase-resistant penicillin (eg, methicillin) is the primary drug of choice to treat *S. aureus*. However, a cephalosporin or erythromycin is also effective. Penicillin G should also be administered to better cover for beta-hemolytic streptococcus and to broaden the spectrum to include anaerobic organisms (eg, *Clostridium*). As a third drug, an aminoglycoside (eg, gentamicin) may also be added to protect against gram negative organisms.

Hospitalization and surgery are warranted when the bite is more than 24 hours old or when cellulitis, lymphangitis, abscess, marked edema, or joint involvement is present. At the time of surgery, meticulous debridement of wound margins (infection control with a knife) is essential. The wound is extended proximally and distally outside the zone of injury for better appreciation of the degree of injury. All granulation tissue and necrotic debris must be removed. The MP joint is inspected for articular cartilage damage, irrigated with a minimum of 2 liters of normal saline, and drained. Wound margins created surgically may be loosely approximated, but the original

bite wound is never sutured but rather allowed to heal by second intention. A gauze wick should be placed into the wound and open joint. However, the wound should not be densely packed with dressings as this may interfere with wound drainage. The involved digit should be immobilized until all signs of infection including discharge, pain, swelling, and redness are absent. If necessary, a repeat debridement is carried out at 48 hours postoperatively. Nerve and extensor tendon repair should be delayed for at least 5 days or until the wound is clean.

Miller and Winfield<sup>9</sup> found wound healing time was clearly dependent upon whether the patient presented early or late following the initial injury. With early presentation, wound healing time measured 8.5 to 10 days versus 34 days for wound healing in those patients who presented late. Chuinard and D'Ambrosia<sup>10</sup> found that the average recovery time to attainment of functional status occurred in 5 weeks for those patients presenting early but was delayed for 10 weeks in late presenters.

Clearly the result of inadequate or delayed treatment of human bite injuries is loss of function. The time lag between injury and treatment is the most important factor in control of infection severity. In 1981, Mann<sup>11</sup> discovered that a delay of greater than 12 hours produced complications in 60% of patients studied. These complications included abscess formation, soft tissue necrosis and gangrene, suppurative tendinitis, periostitis, osteomyelitis, septic arthritis, ankylosis of joints, tendon destruction, and hepatitis B.

### Flexor Tenosynovitis

No hand infection produces greater disability if not treated expeditiously and properly. An untreated pyogenic flexor tenosynovitis destroys the flexor tendon gliding mechanism, producing adhesions and decreased range of motion. The blood supply of the flexor tendon is similarly destroyed, leading to tendon necrosis. The ring, middle, and index fingers are most commonly involved.

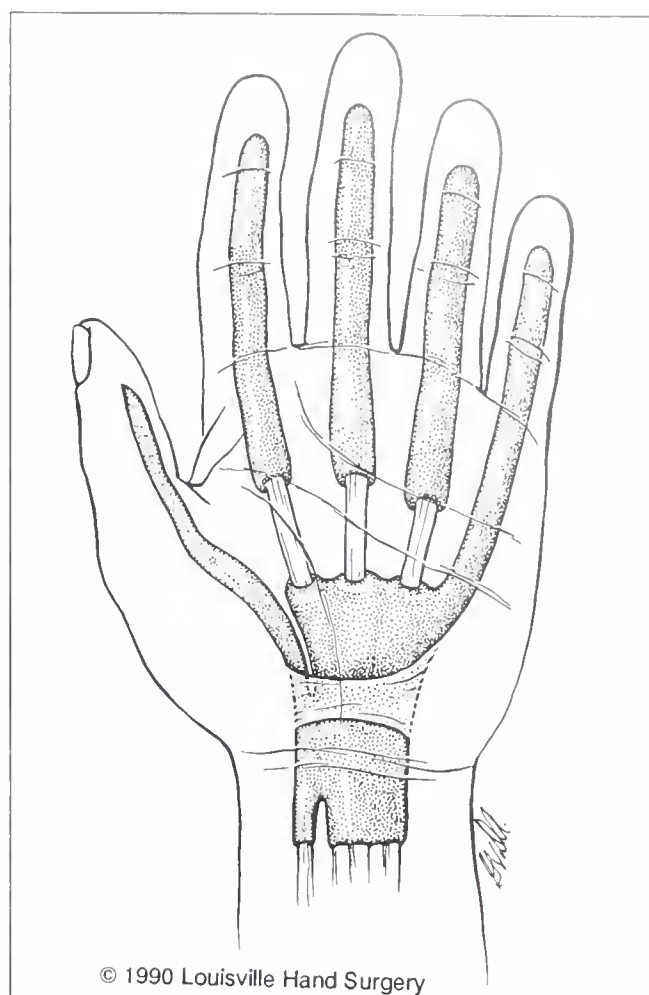
The flexor tenosynovium covers the flexor tendon with both a visceral and parietal layer. At the base of the thumb metacarpal, the sheath of the flexor pollicis longus (FPL) tendon narrows where it communicates with the radial bursa. The radial bursa envelopes the FPL tendon and occasionally the index finger profundus tendon proximal to the digital flexor tendon sheath. At

the neck of the small finger metacarpal, the flexor tendon sheath communicates with the ulnar bursa. The ulnar bursa envelops the flexor tendon of the small finger and may extend into Parona's quadrilateral space of the forearm producing symptoms of median nerve compression when infected. Both the radial and ulnar bursae extend two centimeters proximal to the flexor retinaculum of the wrist communicating with each other approximately 50% of the time, which explains the "horseshoe" configuration of concurrent radial and ulnar bursal infection (Fig 2).

A penetrating wound is the most common route of inoculation. However, hematogenous spread can occur most commonly with gonococcal infections. The organisms most frequently involved in suppurative flexor tenosynovitis are *S. aureus*, *Streptococcus* and *Pseudomonas*.

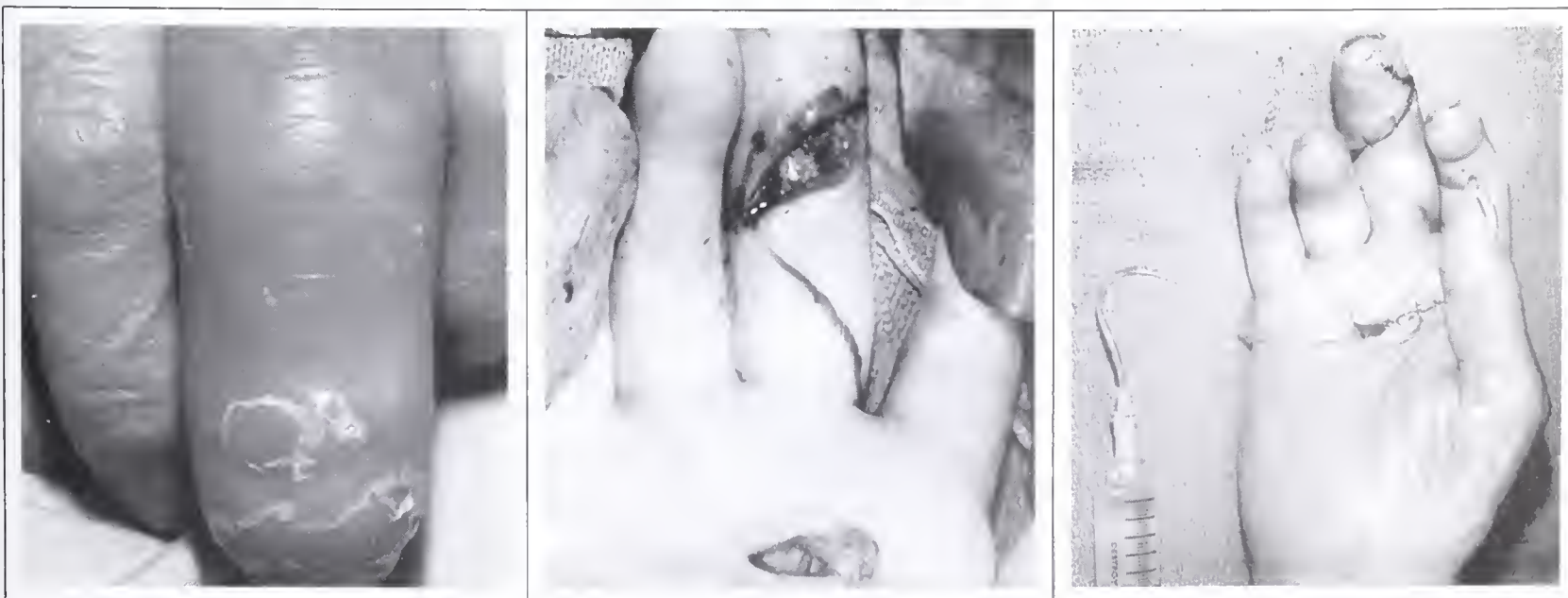
Kanavel's<sup>12</sup> four cardinal signs are used to diagnose flexor tendon sheath infections. These include (1) tenderness over the flexor tendon sheath; (2) symmetrical or fusiform swelling of the digit; (3) pain with passive extension of the digit; and (4) a fixed flexed posture of the involved digit. There may be associated lymphangitis, lymphadenopathy and fever.

When seen within the first 24 to 48 hours of onset, pyogenic flexor tenosynovitis can be aborted by parenteral antibiotics, immobilization, elevation, and close observation. If the process



**Fig 2 — The radial and ulnar bursae and their relation to each other and to the flexor tendon sheaths.**

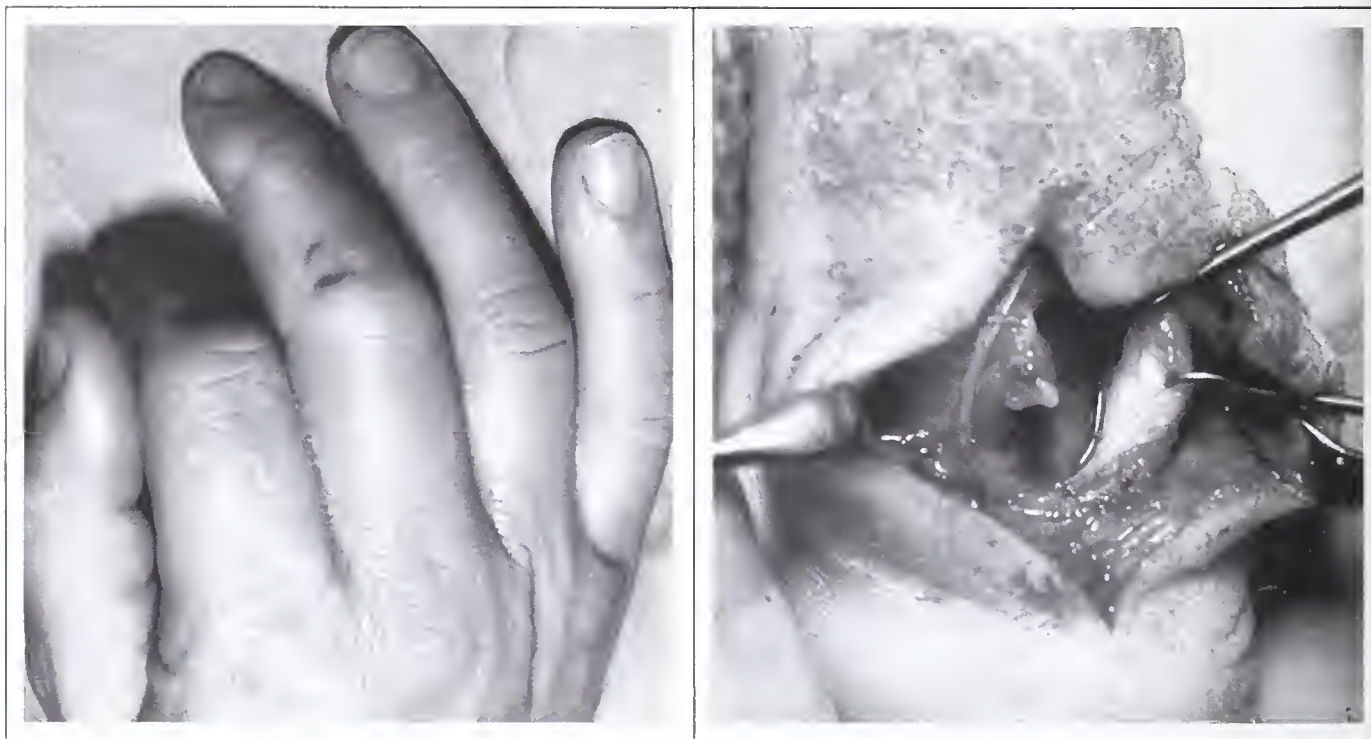
is greater than 48 hours old, incision and drainage is always necessary (Fig 3). Closed tendon sheath irrigation is popular because it allows thorough



**Fig 3 — (A) Suppurative tenosynovitis of right middle finger demonstrating Kanavel's cardinal signs. (B) Transverse incisions over distal palmar and distal interphalangeal creases provide drainage for and access to the fibro-osseous canal. (C) Insertion of irrigation catheter for postoperative flexor tendon sheath lavage. (Courtesy of Joseph E. Kutz, MD)**



## Upper Extremity Wound Management



**Fig 4 — (A) Cat bite of right middle finger with swelling and cellulitis. (B) Surgical exploration revealed intraarticular involvement of the proximal interphalangeal joint. (Courtesy of Thomas W. Wolff, MD)**

drainage without the disadvantage of extensive digital dissection. In the presence of a very severe flexor tenosynovitis, open drainage is preferred.

### Dog Bites

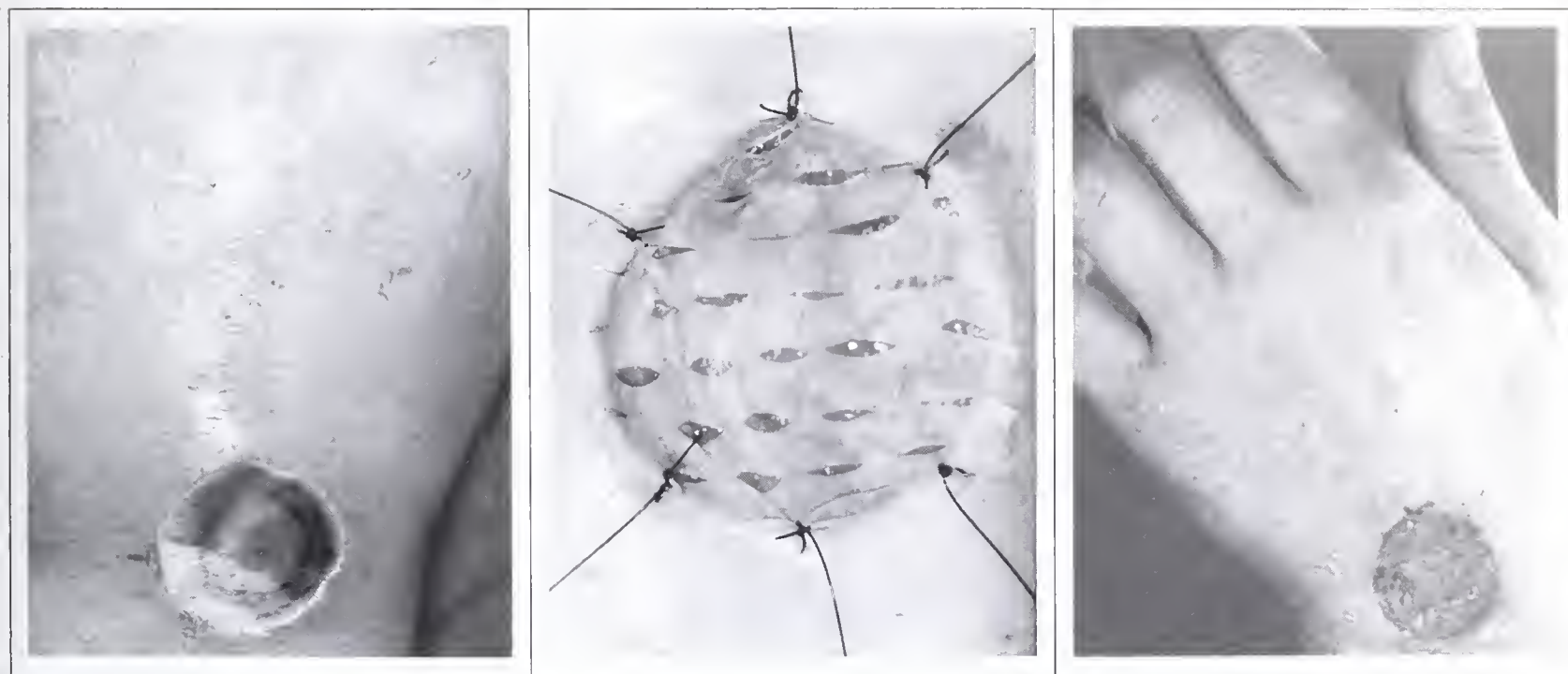
Dog bites are a common problem responsible for approximately 1% of emergency room visits and 80% to 90% of all animal bites. Although dog bite wounds elsewhere in the body may be sutured after debridement and irrigation, dog bites of the hand are more prone to infection and should never be primarily closed. The risk factors determining the likelihood of wound infection include patient age greater than 50 years, a delay of greater than 24 hours in seeking medical therapy, and the presence of puncture wounds, which are much more likely to become infected.<sup>13</sup> A dog bite can exert pressures of 200 to 450 pounds per square inch, sufficient to perforate sheet metal.

The average dog's mouth harbors over 64 species of bacteria including *S. aureus* and *Pasteurella multocida*, both of which are known pathogens. Twenty-three percent of dog bite wounds yield more than one species of organism, but no one organism accounts for greater than 15% of infections. *Pseudomonas* is cultured in 10% of

infected wounds, *S. aureus* in 15% of infections and *Pasteurella multocida* in 20% to 25% of infections. In addition, diphtheroids, *Streptococcus viridans*, *Micrococcus*, and *Moraxella* are also cultured from dog bite wounds. A penicillinase-resistant penicillin or cephalosporin should therefore be the initial drug of choice with erythromycin or tetracycline indicated for those patients allergic to penicillin.<sup>14</sup>

Above and beyond local wound infection, known complications from dog bites include lymphangitis, osteomyelitis, meningitis, brain abscess, and sepsis with disseminated intravascular coagulopathy. The treating physician must always consider rabies in any patient sustaining a dog bite. Hand wounds present a special problem as 30% or more of dog bites to the hand become infected. The involvement of the avascular tendon and tendon sheath space and the propensity for spread of such infection can produce disastrous results following a dog bite.

Although disagreement exists regarding the management of dog bite wounds, most authors agree that aggressive debridement, irrigation, elevation, complete immobilization of the hand, and prophylactic antibiotics are essential. Dog bite wounds should probably not be sutured, al-



**Fig 5 — (A) A brown recluse spider bite upon presentation. (B) After debridement and skin grafting. (C) Two weeks after surgery.**

though the above treatment measures, in particular aggressive debridement and irrigation, probably play a greater role in successful healing than does the presence or absence of a skin closure.

### Cat Bites

Domestic cat bites account for only 5% of all bites inflicted in humans. Cats' teeth are short and sharp and therefore the wounds produced in hands are puncture wounds. The organisms involved reflect the flora of the cat's mouth and the skin flora of the victim. Puncture wounds tend to collapse, which obliterates their entrance, thus becoming a nidus for proliferation of anaerobic bacteria. The puncture wound should be completely excised (Fig 4). After debridement and irrigation, more extensive wounds are left open, but simple wounds may be debrided and closed.

Rabbits, rats, hamsters, guinea pigs, and monkeys inflict wounds similar to cat bites, which can be treated in the same manner.

### Arthropod Bites

There are 80,000 species of arthropods, which are implicated in far more poisonous bites to hu-

man beings than all other phyla combined. Almost all spiders (approximately 20,000 species) are venomous. Ticks, caterpillars, assassin bugs, moths, butterflies, grasshoppers, and other arthropods also include a number of poisonous species. Arthropodal venoms are extremely complex and diversified substances. More than three times as many people in the United States die from arthropod bites and stings than from rattlesnake bites.<sup>15</sup> However, the majority of arthropod-inflicted deaths are secondary to anaphylactic response rather than to the direct effect of the arthropod's venom.

Treatment includes cold compresses, excision of the lesion in the operating room, administration of calcium gluconate, diazepam and methocarbamol, analgesics, antihistamines and corticosteroids, antivenom, antibiotics, and tetanus prophylaxis (Fig 5).

The recommendations of an expert in envenomation injuries should always be obtained to assist the treating physician in the management of these complex and potentially lethal bites.

**ACKNOWLEDGMENTS:** We would like to thank Drs Joseph E. Kutz, Thomas W. Wolff, and James M. Kleinert for inclusion of their



## Upper Extremity Wound Management

patients in this article, Kell Julliard for his assistance in writing and editing the manuscript, and the Media Services department of the Christine M. Kleinert Institute for Hand and Micro Surgery for photography and illustration.

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# Resection of Renal Cell Carcinoma With Vena Cava Extension Using Circulatory Arrest

Allan M. Lansing, MD; Frederick R. Witten, MD; Zahi H. Masri, MD;  
John G. Hubbard, MD

*Resection of renal cell carcinoma with extension into the inferior vena cava can result in massive blood loss, incomplete removal of the tumor, and systemic dissemination of malignant cells. A case is presented in which circulatory arrest with total body exsanguination permitted relatively safe resection in a bloodless operative field.*

Extension through the renal vein and into the inferior vena cava (IVC) is a pathologic complication in 4% to 15% of renal cell carcinomas.<sup>1-5</sup> Aggressive propagation is further evidenced by reports of right atrial involvement in 15% to 40% of patients with tumor in the vena cava.<sup>6,7</sup> Removal of these tumors without excessive blood loss or neoplastic embolization can be technically difficult. In the past decade, the use of cardiopulmonary bypass with circulatory arrest and total body exsanguination has allowed relatively safe resection in a bloodless operative field.

## Case History

A 56-year-old white male presented with the singular complaint of gross hematuria. The patient's medical history was negative in all respects. Hemoglobin was 11.5 gm/dL with a hematocrit of 30.5%. Renal function was normal and urinalysis showed microscopic hematuria. Liver function tests were all within normal range. Bilirubin was 0.4 mg/dL, alkaline phosphatase was 76 mg/dL, blood urea nitrogen was 16 mg/dL, and serum creatinine was 0.9 mg/dL. Intravenous pyelogram, computed tomography, and renal sonography showed a large right hypernephroma with a 3 cm extension into the vena cava. The extensive neovascularity of this mass was demonstrated by renal arteriography (Figs 1 and 2). Inferior vena-



**Fig 1 — Renal arteriogram showing extensive neovascularity of right renal mass.**



**Fig 2 — Right renal mass demonstrated by renal arteriography.**

*From the Humana Heart Institute International (Drs Lansing and Masri) and the Department of Surgery, Humana Hospital Audubon (Drs Witten and Hubbard), Louisville, KY.*



## Resection of Renal Cell Carcinoma



**Fig 3 — Inferior venocavogram showing invasion of right renal tumor into right vena cava upward to level of hemidiaphragm.**

cavography showed invasion upward to the level of the hemidiaphragm (Fig 3). Metastatic work-up included a bone scan and chest x-ray, but distant disease was not found.

Under general endotracheal anesthesia, the patient was placed in the supine position with a roll under the right sacroiliac area and hyperextension of the operating table (Fig 4). Sternotomy was performed and preparation made for can-

nulation of the right atrium and aorta. The chest incision was then extended along the linea alba halfway to the umbilicus and a transverse abdominal incision made on the right side extending laterally to the tip of the 12th rib (Fig 4).

The large right renal tumor was seen to push the colon anteriorly. The IVC was dissected from below the renal veins to the caudate lobe of the liver. Umbilical tape was used to encircle the IVC within the pericardium to prevent tumor tissue migration to the lungs and backflow from the right atrium.

The patient was then heparinized and the right atrium and superior vena cava cannulated along with the aorta. Cardiopulmonary bypass was begun. Over a 30-minute period, the patient was cooled to a rectal temperature of 19°C and an esophageal temperature of 17°C. Perfusion was arrested and the near-total circulatory volume diverted to the venous reservoir. The vena cava above the diaphragm and the left renal vein were occluded with tourniquets and the vena cava clamped below the renal veins. The vena cava was then incised vertically immediately adjacent to the orifice of the right renal vein and the incision carried superiorly above the tumor (Fig 5). At this time only external wall suction was used in order to prevent aspiration of tumor cells to the heart-lung machine.

The tumor was densely adherent to the renal vein at its orifice but was free within the vena cava. The renal vein and tumor were mobilized out of the operative field and the incision in the vena cava was closed. Cardiopulmonary bypass was then reinstituted. The patient was rewarmed and the heart defibrillated when core temperature reached 26°C. During the rewarming period, a radical nephrectomy was carried out, which included Gerota's fascia, the surrounding perirenal fat, and the right adrenal gland. Bypass was discontinued and heparinization neutralized with protamine sulfate. The retroperitoneum was inspected but no positive lymph nodes were found. Estimated blood loss was 1900 cc. The period of circulatory arrest was 17 minutes. Thiamylal sodium was administered during circulatory arrest and dexamethasone immediately post-arrest for cerebral protection.

Pathologic examination revealed a right kidney and tumor 15 × 10 × 7 cm weighing 650 gm. The capsule of the kidney was intact and the 9 × 5 cm solid tumor involving both the cortex and medulla was identified as a clear cell adenocarcinoma. This extended just beneath the capsule

but did not penetrate it.

The patient recovered uneventfully and was discharged home on the 7th postoperative day. No local recurrence or metastasis has been evident in 1 year of follow-up.

## Discussion

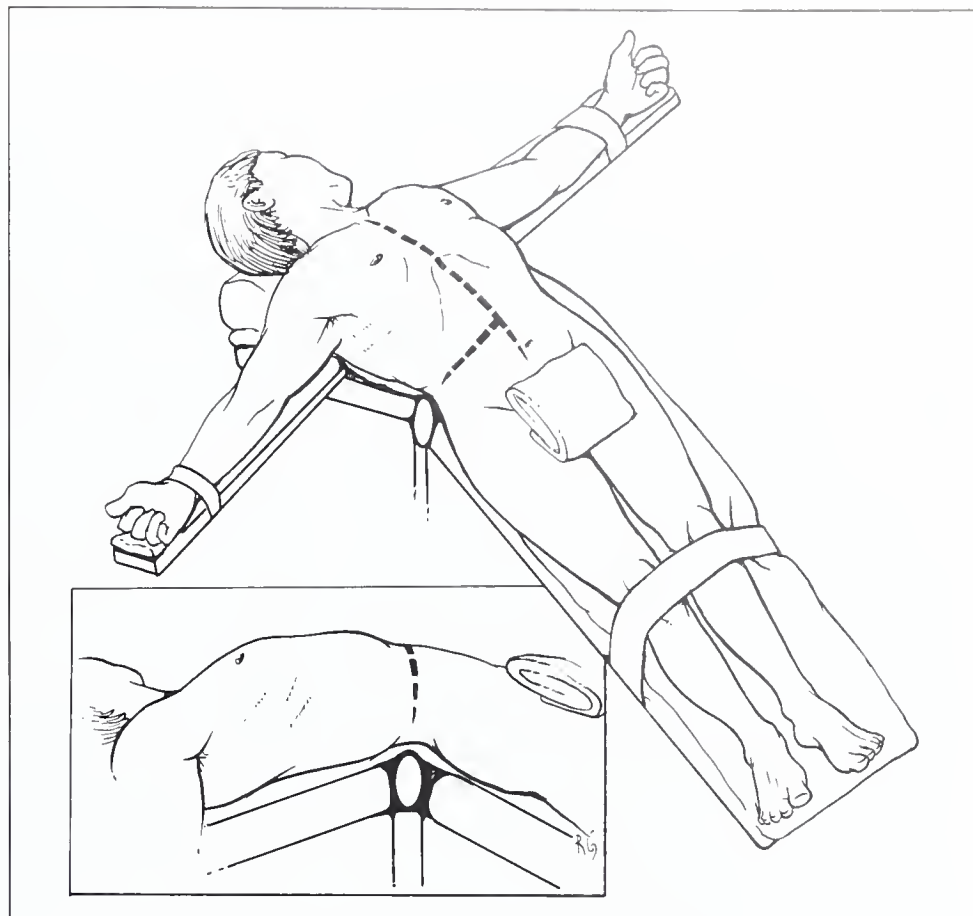
Resection of renal cell carcinoma with extension of the tumor into the inferior vena cava can be technically demanding. Exposure of the inferior vena cava itself can be difficult, and the plexus of major infradiaphragmatic vascular channels can lead to massive blood loss, hurried and inaccurate removal of the tumor, and dissemination of the tumor into the operative field.<sup>8</sup>

Circulatory arrest with total body exsanguination has become accepted practice in the resection of these tumors, particularly those that have grown into the right atrium or are adherent to the caval lumen. The safety of this technique relative to cerebral complications and blood loss has been upheld by numerous series.<sup>2, 3, 7-10</sup> With cerebral oxygen demands decreased by barbiturate administration during profound hypothermia, 40 to 60 minutes is thought to be the margin of risk.<sup>9, 10</sup>

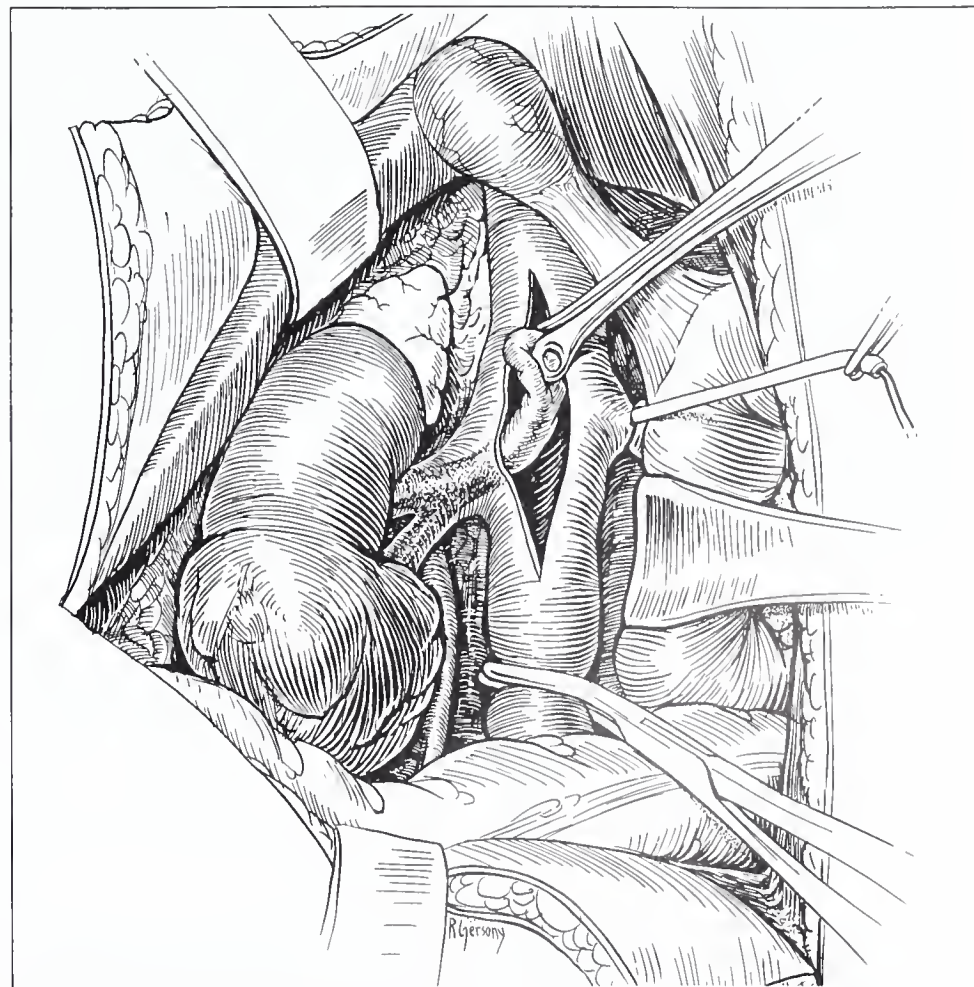
The mean intraoperative blood loss for right-sided tumors is a third less than for those involving the left kidney.<sup>4</sup> When cardiopulmonary bypass was used in one series, blood loss ranged from 500-3500 cc with a mean of 2000 cc.<sup>9</sup> Other series without cardiopulmonary bypass have reported nearly double these intraoperative blood losses.<sup>4, 5</sup> The relatively low blood loss (1900 cc) and circulatory arrest time (17 minutes) in the case presented may be attributable to the fact that the tumor could be completely excised and was not friable.

Pathologic staging places this tumor as Stage C<sup>11</sup> or in the pT3c (TMN) classification. This indicates a capsular-confined tumor with extension into the vena cava and without regional lymph node involvement. Associated factors indicating a poor prognosis are renal vein involvement, positive renal lymph nodes, extension through Gerota's fascia, local extension to other organs, or metastasis.<sup>12</sup> In the absence of these factors, infradiaphragmatic extension seems to have a prognosis similar to lower stage tumors.<sup>6</sup>

When non-metastatic tumors have been considered solely by their vena cava involvement, survival has been seen to be vastly improved, with 5-year survival rates ranging from 47%<sup>4, 13</sup> to 75%.<sup>7</sup>



**Fig 4 — Patient in supine position with hyperextension of sacroiliac area.**



**Fig 5 — Excision of right renal tumor extension from inferior vena cava.**



## Resection of Renal Cell Carcinoma

Incomplete resection is associated with a worsened prognosis, especially in tumors extending above the level of the diaphragm or above the hepatic veins, because of the difficulty in extracting intracaval tissue from these sites.<sup>5,9</sup> Left-sided tumors account for only 29% of renal cell carcinomas but are thought to lessen the survival rate.<sup>1</sup> This is perhaps due to the longer length of the left renal vein through which the tumor progresses into the vena cava, thus delaying the onset of symptoms.

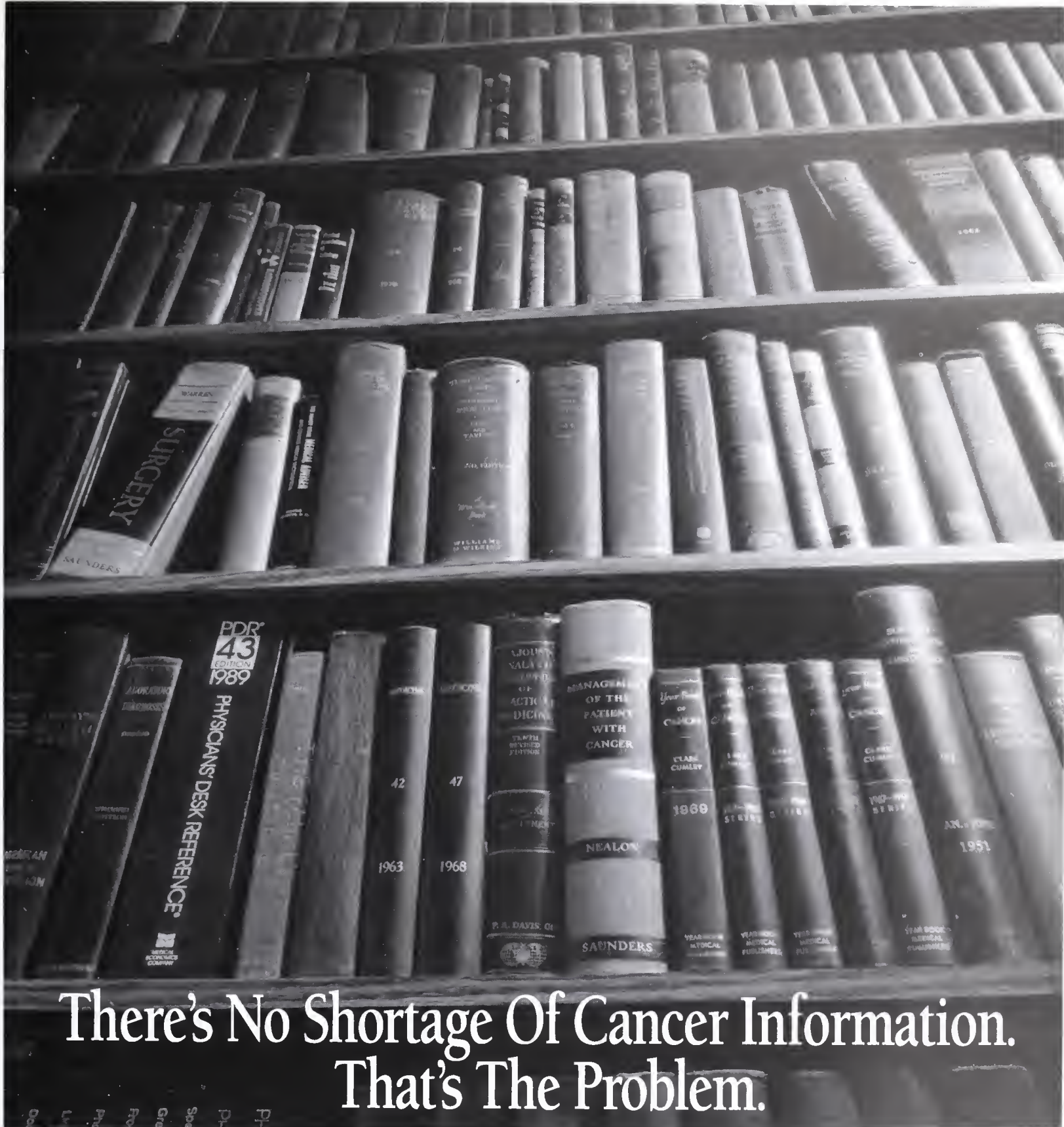
Ancillary treatment options for renal cell carcinoma have generated poor success rates. Chemotherapy has shown disappointing results, with only a 7% objective response rate.<sup>14</sup> Combination chemotherapy has not proven more successful than single agents.<sup>15</sup> Likewise, little evidence exists to support preoperative or postoperative radiotherapy other than as palliative treatment for bone metastasis.<sup>15</sup>

## Summary

A patient with vena caval extension of a renal cell carcinoma underwent resection with circulatory arrest and total body exsanguination. No metastasis has been evident in the first year of follow-up. Circulatory arrest permits removal of the tumor without excessive blood loss or dissemination of tumor cells.

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# Health Promotion: The Physician's Changing Role

Few events in the 20th Century rival the impact of the emergence of medical science and technology and its profound influence on disease control. As the agents of mortality have shifted from the endemic and epidemic communicable diseases to chronic disease states, the definition of health has expanded beyond the mere absence of disease to encompass the complete physical, mental, and emotional well-being of the individual and the community. That physicians should be intensely involved in this concept of health promotion seems a natural rather than novel concept, yet, as the social understanding of health has evolved, the physicians' response has all too often been slow and, in some instances, unnoticeable.

Physician participation in health education and promotion extends to several potential arenas, but none more tangible than the clinical practice setting. Evidence suggests that up to 75% of the diseases we commonly encounter, along with their concomitant complications, remain preventable with early detection and intervention. Recent work from the US Preventative Services Task Force and the Canadian Task Force on the Periodic Health Examination provides much of the data and structured analysis of evidence that has limited the implementation of preventative techniques in the past. Yet, while the clinical setting comprises most often our primary health related interface with the community, it likewise presents some significant barriers to the practice of health promotion as elucidated by Lawrence in a recent commentary.<sup>1</sup>

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***“Ultimately, the physician must encourage the development of individual and community responsibility for health education and promotion.”***

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In many ways the traditional problem-oriented approach to medicine comprises the major obstacle to health promotion. Our tradition, our training, our practice construct, and our reimbursement are grounded in the treatment of disease and the amelioration of suffering. However, with the problem-oriented encounter, the patient and physician interact largely well beyond the potential scope of primary and secondary prevention. In order to utilize these venues of patient care, we must restructure our approach. From the standpoint of the physician, this restructuring requires, initially, a reorientation of graduate, postgraduate, and continuing medical education to include issues of health promotion. We must begin to utilize the problem-oriented patient encounter as an opportunity to exercise clinical prevention skills, become increasingly selective in our choice of tests and interventions, demand more investigation into the utility and effectiveness of available

and potential preventative services, and include the skills of allied health professionals and educators in our health education and promotion endeavors.

Ultimately, the physician must encourage the development of individual and community responsibility for health education and promotion. As we understand patient choice and its ultimate influence on the development of disease or the promotion of health, it becomes incumbent on physicians to facilitate the growth of the patient's health data base and the patient's health-related decision making. It further demands that we elucidate the need for expanded reimbursement for access to preventative services. It requires our encouragement of and support for community based health endeavors, such as auto safety and poison prevention campaigns, disease reporting and immunization efforts, and community health education center development.

Our role as health care providers is changing. The social and economic burden of the treatment of disease as life expectancy encroaches on the ninth decade of life is becoming overwhelming. It is our duty to project ourselves as advocates in the movement beyond disease control to health promotion for our patients and our community.

**Daniel W. Varga, MD**

1. Lawrence RS. Commentary. *Health Affairs*. 1990;9(2):122-132.



## SEPTEMBER

**14 — Lasers and Beyond**, presented by N. D. Radtke, MD, and Humana Hospital Audubon. Category I credit. Contact: N. D. Radtke, MD, 240 Audubon Medical Plaza, Louisville, KY 40217; 502/636-2823.

**20 — Clinical Update for Ophthalmic Nurses and Technicians**, Radisson Plaza Hotel, Lexington, KY. Contact: Kay Montgomery, The Center for Advanced Eye Surgery, Humana Hospital-Lexington, 150 N Eagle Creek Dr, Lexington, KY 40509; 606/268-3754.

**20-21 — Clinical Advances in Cataract, Glaucoma and Corneal Surgery**, Humana Hospital-Lexington. Contact: Kay Montgomery, The Center for Advanced Eye Surgery, Humana Hospital-Lexington, 150 N Eagle Creek Dr, Lexington, KY 40509; 606/268-3754.

**21 — Corneal-Contact Lens Update 1991**, Radisson Plaza Hotel, Lexington, KY. Contact: Kay Montgomery, The Center for Advanced Eye Surgery, Humana Hospital-Lexington, 150 N Eagle Creek Dr, Lexington, KY 40509; 606/268-3754.

## OCTOBER

**11 — Practical Diabetes Management Symposium for the Primary Care Physician**, Marriott Griffin Gate Resort, Lexington. Presented by The Diabetes Center of Excellence at Humana Hospital, Lexington. Contact: Kay Montgomery, Humana Hospital-Lexington, 150 N Eagle Creek Dr, Lexington, KY 40509; 606/268-3754.

**27-November 1 — Twenty-Second Family Medicine Review — Session III**; Hyatt Regency Hotel, Lexington, KY. Contact: Ms Joy Greene, Director CME, 132 College of Medicine Office Bldg, U of K, Lexington, KY 40503-0086; 606/233-5161.

## NOVEMBER

**4-8 — 57th Annual Scientific Assembly of the American College of Chest Physicians**, San Francisco Marriott and the Moscone Center, San Francisco, CA. Contact after June 20, 1991: American College of Chest Physicians, Division of Education, 3300 Dundee Rd, Northbrook, IL 60062-2348; 708/498-1400.

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# AKMA Connections

AKMA FALL BOARD MEETING  
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The AKMA serves as a representative to the American Medical Association Auxiliary. Each year, delegates are sent to the AMAA Annual Convention to participate in training sessions, to receive updated information on concerns to medicine, and to serve as advocates for the interests of the members of our state organization. Representation on the national level of the organization affords us the opportunity to have a voice in the decision-making processes of the federation.

The support of medical education has been a primary goal of the Auxiliary for many years. Each year, thousands of dollars raised through fund raising for AMA-ERF are provided to medical schools to be used for scholarships, for assistance for emergency needs of students, and for the expansion of programs to improve

the quality of medical education. The AKMA encourages and supports the component auxiliaries in their fund raising efforts for medical education.

Training and networking are also primary focus areas of the Auxiliary to the KMA. This August, training sessions will be held in Lexington and Bowling Green that will target the county auxiliary needs. The state chairmen and an AMA Auxiliary representative will be available to assist county auxiliary officers and interested members in developing programs and projects to fit the needs of their individual communities.

The session in Lexington will be held August 27 at the Marriott's Griffin Gate and is designed to accommodate those auxiliaries living in the eastern half of the state. The session in Bowling Green will be held August 28 at the Greenwood Executive Inn and is designated for those auxiliaries living in the western portion of the state.

Financial assistance is available through the AKMA to assist Kentucky residents pursuing careers in health-related fields. A portion of each auxiliaries dues is designated to help maintain this Health Careers Fund. As

the need for quality health care workers increases, the Auxiliary continues to assist as many students as possible.

Support of medicine is the connection that all auxiliaries share. Whether monitoring legislation, fund raising for medical education, assisting students and their spouses, networking on medical issues, sharing trends, or promoting local health projects, Auxiliary members throughout the Commonwealth share in their advocacy for medicine and the medical profession.

For information concerning membership or any Auxiliary projects or promotions, contact:

Jean Wayne  
AKMA Executive Secretary  
301 N Hurstbourne Pkwy  
Suite 200  
Louisville, KY 40222  
502/426-6200

*Sam Blackstone*

**AKMA President**



Dear Carl,

Congratulations on your new medical staff leadership position! Now you're not only a physician — you need to be a manager, negotiator, arbitrator, and even a parliamentarian. I wish I had received some special training when I first took a position like yours!

Sincerely,

Helen

## Do you have the skills to do the job?

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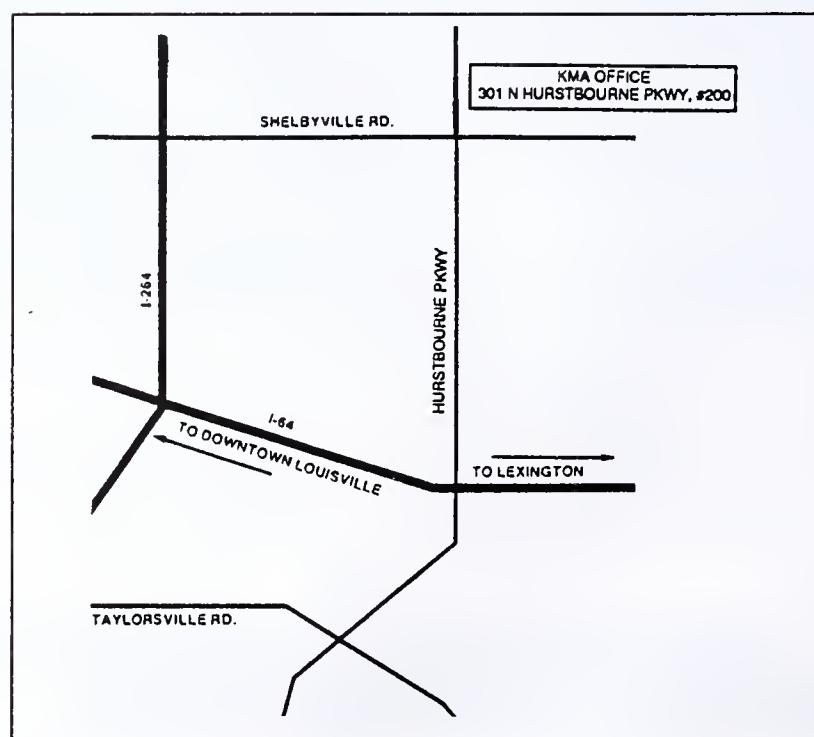
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# Prevention:

**Rx for Health Care in the 90s**

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*KMA Annual Meeting · Sept 29 - Oct 3*  
*Hyatt Regency Hotel · Lexington, KY*

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# Official Call KMA Annual Meeting

**T**o the officers and members of the component and county medical societies of the KMA.

## **Meeting Place**

The Annual Meeting of KMA will convene on Tuesday, Wednesday, and Thursday, October 1, 2 & 3, at the Hyatt Regency Hotel and Lexington Center, Lexington. The first General Session will be called to order at 8:50 am, Tuesday.

## **The House of Delegates**

The first regular meeting of the House of Delegates will convene at 9:00 am, Monday, September 30, in the Regency Ballroom, located in the Hyatt Hotel. The second regular business meeting will begin at 7:00 pm, Wednesday, October 2, in the Patterson Ballroom.

## **Registration**

The Registration Desk, located outside the Regency Ballroom, Lobby Level of the Hyatt Hotel, will be open for Delegates at 7:30 am, Monday, September 30, and at 6:00 pm, Wednesday, October 2. General registration will be held from 7:45 am until 5:00 pm, Tuesday and Wednesday; and 7:45 am to 3:30 pm on Thursday, at the General Registration Desk located in the lobby of the Lexington Center.



## KMA Officers 1990-91



**Preston P. Nunnelley, MD**  
KMA President

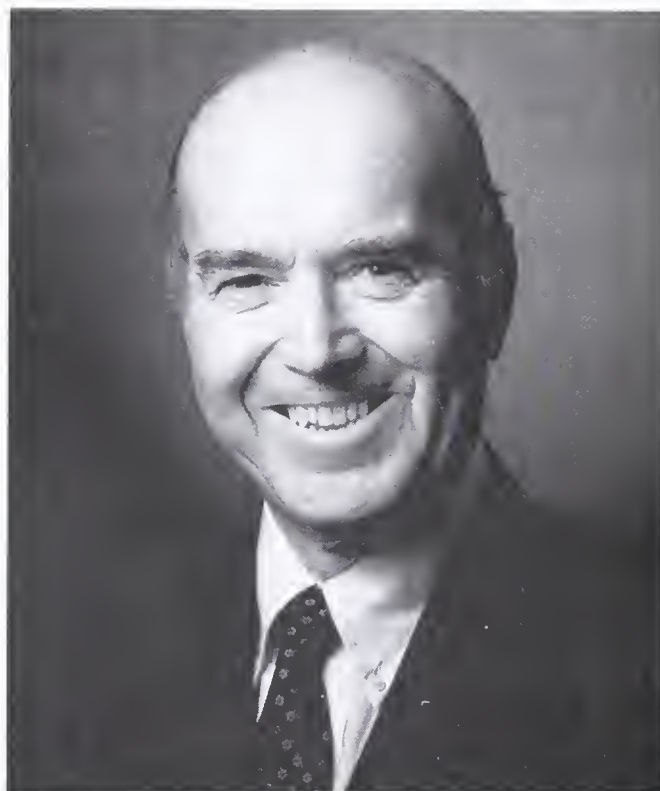
On October 2, Preston P. Nunnelley, MD, Lexington, will pass the leadership of the Kentucky Medical Association to S. Randolph Scheen, MD, of Louisville.

Dr Nunnelley, a native of Mt. Vernon, Kentucky, received a Bachelor of Science degree from Eastern Kentucky University, Richmond, in 1964, and an MD degree from the University of Kentucky College of Medicine in 1970. He completed a residency in OB-GYN at the U of K Albert B. Chandler Medical School in 1974 and has been in a partnership practice since that time.

A fellow of the American College of Obstetrics and Gynecology, Dr Nunnelley is also a member of the AMA, American Fertility Society, and a past president of the Kentucky Obstetrical and Gynecological Society and the Fayette County Medical Society.

In addition to his past year's service as President, Dr Nunnelley served KMA as 10th District Trustee for 5 years and has served as Vice Chairman of the Board of Trustees. Current committee memberships include Kentucky Physician's Care Operating, Scientific Program, and Professional Liability Insurance.

KMA is fortunate to have had such a strong and dedicated leader as Dr Nunnelley.



**S. Randolph Scheen, MD**  
President-Elect

S. Randolph Scheen, MD, Louisville, will be installed as President of the Kentucky Medical Association at the President's Luncheon on Wednesday, October 2.

Dr Scheen's extensive service to KMA began in 1967 when he was elected Secretary. In 1975, the offices of Secretary and Treasurer were combined, and Dr Scheen has served in the capacity of Secretary-Treasurer since that time. Current committee memberships include Scientific Program, Awards, and Professional Liability Insurance.

Long active in organized medicine, Dr Scheen is a past Vice-President of the Jefferson County Medical Society and is also a member of the American Academy of Dermatology, Alumni Foundation of Mayo Clinic, and a regular participant on local television and radio programs.

A native of Louisville, Dr Scheen received a bachelor of science degree from the University of Louisville, followed by a medical degree from the University of Louisville School of Medicine in 1953. He served his internship at the former St. Joseph Infirmary, Louisville, and completed a residency in dermatology at Louisville General Hospital. Dr Scheen is in the private practice of dermatology in Louisville.



Vice President  
**William B. Monnig, MD**  
Edgewood

Dr Monnig, a urologist, is in private practice in Northern Kentucky. He served KMA as 8th District Trustee from 1984 until 1990 and Chairman of the Board of Trustees from 1987 to 1990. Current committee memberships include State Legislative Activities, Professional Liability Insurance, Medical Insurance & Prepayment Plans, and Physician-Attorney Liaison. A 1969 graduate of the University of Cincinnati College of Medicine, Dr Monnig is a member of the American Urological Association and a fellow of the American College of Surgeons.



Secretary-Treasurer  
**William P. VonderHaar, MD**  
Louisville

A family practitioner, Dr VonderHaar has served on the Interspecialty Council, Professional Education Committee, and served as a Delegate for Jefferson County for several terms. He currently serves on the KMA Continuing Medical Education Committee, and is a charter fellow of the American College of Family Physicians and a member of the American Academy of Family Physicians. Dr VonderHaar was a recipient of KMA's Educational Achievement Award in 1988. He is a 1956 graduate of the University of Louisville School of Medicine.



Speaker of the House  
**Danny M. Clark, MD**  
Somerset

Dr Clark is an OB-GYN from Somerset and a 1962 graduate of the University of Cincinnati College of Medicine. He served KMA as Delegate from 1974-1980; 12th District Alternate Trustee from 1977-1980; 12th District Trustee from 1980-86; and Vice Speaker of the House from 1986-1989. He currently serves as Chairman of the Committee on Maternal and Child Health. Dr Clark is a fellow of the American College of Obstetricians and Gynecologists.



Vice Speaker of the House  
**C. Kenneth Peters, MD**  
Louisville

Dr Peters, a family practitioner, has served KMA as KEM-PAC chairman, on the Legislative Committee 14 years, and has been a KMA Delegate 20 years. He is immediate past president of the Jefferson County Medical Society, a Charter Fellow of the American Academy of Family Practitioners, and a member of the Jefferson County Academy of Family Practitioners. Dr Peters is a 1960 graduate of the University of Louisville School of Medicine.



## KMA Delegates to AMA



**Donald C. Barton, MD**  
Corbin

Dr Barton, a family practitioner, was elected AMA Delegate in 1984. A past Chairman of the KMA Board of Trustees and past President of the Association, Dr Barton served as KMA Delegate from 1977-79 and AMA Alternate Delegate in 1983. He is past President of the Whitley County Medical Society; past chairman of the KEMPAC Board; and was 15th District KMA Trustee from 1978-84. Dr Barton, a 1960 graduate of the University of Louisville School of Medicine, serves on numerous KMA committees.



**Wally O. Montgomery, MD**  
Paducah

Dr Montgomery, a general surgeon, was elected AMA Delegate in 1988. He has served KMA as President, Alternate AMA Delegate, Board Chairman of KEMPAC, and on numerous committees. He is chairman of the Committee on State Legislative Activities and the Ad Hoc Committee on PLI. A 1962 graduate of the U of L School of Medicine, he is a past KY Governor for the American College of Surgeons and a diplomate of the American Board of Surgery. Dr Montgomery is a Colonel in the US Army Reserve, and recently returned from serving as a 332nd Medical Brigade COSCOM Surgeon in Operation Desert Storm in Saudi Arabia.



**Harold L. Bushey, MD**  
Barbourville

Dr Bushey was elected an AMA Delegate in 1989, having previously served as a KMA Delegate for 6 years; Alternate Trustee 1968-1972; 15th District Trustee 1972-1978; and Board Chairman of KEMPAC. He has served on numerous KMA committees and is currently Chairman, Technical Advisory Committee on Physician Services (Title XIX). A 1954 graduate of Rochester Medical School, Rochester, NY, Dr Bushey is an internist. He is a member of the Southern Medical Association and a past secretary of the Knox County Medical Society.



**Robert R. Goodin, MD**  
Louisville

Dr Goodin, an internist, was elected as AMA Alternate Delegate in 1987 and served consecutive terms until his election as a Delegate in 1991. He has served KMA on numerous committees and is currently chairman of the Physician Manpower Committee and the Committee to Investigate Changing Trends in Medicine. Dr Goodin earned his medical degree in 1964 from the University of Louisville School of Medicine. He is a fellow of the American College of Physicians and the American College of Cardiology.

## Journal Editors

### **A. Evan Overstreet, MD, Editor**

Louisville

Dr Overstreet served on the Editorial Board for more than six years before becoming Editor of *The Journal* in September 1977. An internist, Dr Overstreet is a 1955 graduate of the University of Louisville School of Medicine. He is a member of the American Society of Internal Medicine, the American College of Physicians, the Transylvania Medical Society, and former President of the Louisville Society of Internists.

### **Daniel W. Varga, MD**

Louisville

Dr Varga, an internist, joined the *Journal* in 1990 as Scientific Editor. A 1984 graduate of the University of Louisville School of Medicine, Dr Varga has served as an Alternate Delegate to the KMA House of Delegates. He is a diplomate of the American Board of Internal Medicine and a member of the American Association for the Advancement of Science, American College of Physicians, Southern Medical Association, and AMA.

### **Stephen Z. Smith, MD**

Louisville

Dr Smith has served as Assistant Scientific Editor for *The Journal* since 1977. He also serves as book review author. A dermatologist, Dr Smith is a 1971 graduate of Johns Hopkins University School of Medicine. He is a member of the KMA Claims and Utilization Review Committee, the American Academy of Dermatology, and the American Medical Association.

### **Milton F. Miller, MD**

Louisville

Dr Miller is Associate Clinical Professor of Medicine at the University of Louisville School of Medicine. An internist, Dr Miller has served as Assistant Editor of *The Journal* since 1976, has been on the Membership Committee of the Jefferson County Medical Society, and is a former President of the medical staff at Methodist Evangelical Hospital. He is a 1954 graduate of the University of Louisville School of Medicine.

### **Martha Keeney Heyburn, MD**

Louisville

Dr Heyburn joined *The Journal* in 1986 as an Assistant Editor. An ophthalmologist, Dr Heyburn is a 1980 graduate of the University of Louisville School of Medicine. She has served the Jefferson County Medical Society as an Alternate Delegate to KMA, is a member of the American Academy of Ophthalmology, the American Medical Association, and has been a member of KMA since 1981.

### **Jannice O. Aaron, MD**

Louisville

Dr Aaron joined the *Journal* in 1990 as an Assistant Editor. A radiologist, Dr Aaron is a 1977 graduate of the University of Louisville School of Medicine. She served KMA as a Delegate from Adair County in 1985-86 and Jefferson County in 1990. President of the Greater Louisville Radiological Society for 1990-91, she is also a diplomate of the American College of Radiology and the American Society of Neuroradiology and a member of the Radiological Society of North America, New England Roentgen Ray Society, and Southeastern Neuroradiological Society.

### **William P. Hoagland, MD**

Louisville

Dr Hoagland joined the *Journal* in 1991 as an Assistant Editor. A surgeon, Dr Hoagland is a 1983 graduate of the University of Louisville School of Medicine. He has been active in the Jefferson County Medical Society and currently serves on their Business Bureau. Dr Hoagland is a member of several professional organizations including the American College of Surgeons.



## KMA District Trustees



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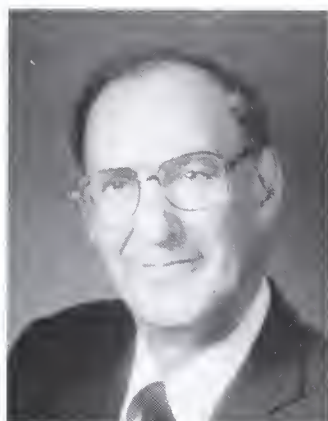


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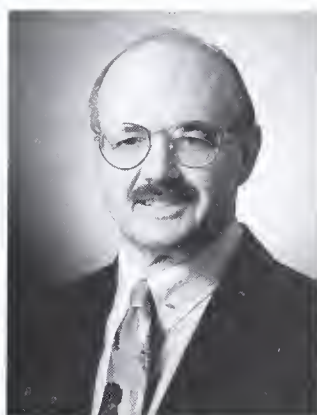




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Fourteenth District



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**Paul R. Smith, MD**  
Fifteenth District



**David C. Liebschutz, MD**  
Twelfth District





## New Trustees

### **Mark F. Pelstring, MD**

Covington

Dr Pelstring is serving as Trustee from the 8th District.

Having joined KMA in 1976, Dr Pelstring's contributions include service as a KMA delegate from 1983 to 1987 and Alternate Trustee from 1987-1990. He is a past president of the Campbell-Kenton County Medical Society, diplomate of the American Board of Family Physicians, a fellow of the American Academy of Family Physicians, and a member of the Kentucky Academy of Family Physicians and the American Society of Addiction Medicine.

Dr Pelstring is a past president of the St. Elizabeth Medical Center and a volunteer instructor in family medicine at the universities of Cincinnati, Louisville, and Kentucky, and a parttime instructor in the St. Elizabeth Medical Center Family Practice Residency Program.

Dr Pelstring graduated cum laude from Thomas More College and magna cum laude from the University of Louisville School of Medicine. He completed a one-year residency at St. Elizabeth Hospital in Covington prior to entering a private family practice in 1975.

### **Paul R. Smith, MD**

London

Dr Smith is serving as Trustee from the 15th District.

He brings many years of experience to his KMA office. He has served as president of the Laurel County Medical Society for more than 9 years and has been a KMA delegate for several years. An active KMA member since 1960, committee memberships include Interspecialty Council, Care for Aging, Community and Rural Health, Advisory Committee on KPRO, Peer Review, and Ad Hoc Committee on Liability Insurance. Dr Smith is also a member of the American Academy of Family Practitioners, Southern Medical Association, and has been an Aviation Medical Examiner for the FAA since 1961. He was selected as Citizen Doctor of the Year by the Kentucky Academy of Family Practitioners in 1989.

Dr Smith earned his medical degree from the University of Louisville School of Medicine in 1956 and interned in 1956-57 at Good Samaritan Hospital, Lexington. He practiced as a flight surgeon in the United States Air Force from 1958 to 1960 and then began his private practice in London. He also serves on the volunteer faculty at the University of Kentucky College of Medicine, Family Practice Department.

### **Joseph E. Kutz, MD**

Louisville

Dr Kutz is serving as Trustee from the 5th District.

Active in KMA since 1963, Dr Kutz is a member of numerous medical societies including the American Society for Surgery of the Hand and the American College of Surgeons. He was active in the formation of two societies — the American Society for Reconstructive Microsurgery, for which he served an 18-month term as president in 1986 and 1987, and the International Society of Reconstructive Microsurgery, for which he is presently serving as treasurer. He is past president of the Jefferson County Medical Society and is currently serving as the president of the Medical Foundation of the Medical Society.

A specialist in surgery of the hand and reconstructive microsurgery in Louisville since 1964, Dr Kutz earned a master's degree from the University of Detroit in 1955 and his medical degree from Michigan Medical School in Ann Arbor in 1958. He served a rotating internship at Springfield City Hospital in Ohio and completed his surgical residency at Louisville General Hospital. Following a one-year fellowship in hand surgery at the University of Louisville School of Medicine, he joined the hand surgery practice of Dr Harold Kleinert in 1964. In 1987, he was appointed Director of the Christine M. Kleinert Fellowship in Hand Surgery. Dr Kutz' current appointment at the University of Louisville School of Medicine is Clinical Professor of Surgery (Hand).

# KMA Delegates

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## Casey

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## Letcher

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John E. Downing, MD, Bowling Green  
Paul J. Parks, MD, Bowling Green

**Washington**

Suk K. Koh, MD, Springfield

**Wayne****Webster****Whitley**

Frank H. Catron, MD, Corbin  
Jagdish S. Patil, MD, Corbin  
Carmel Wallace, Jr, MD, Corbin

**Wolfe**

Paul F. Maddox, MD, Campton

**Woodford****KMA Hospital Medical Staff Section**

David R. Watkins, MD, Louisville

**KMA Resident Physicians Section**

Mark G. Delworth, MD, Lexington

**KMA Student Section**

Daniel Wilde, Louisville  
Matthew Shotwell, Lexington



## Elections

### Nominating Committee to Meet Monday, September 30

The KMA Nominating Committee will hold an open meeting at the close of the first meeting of the House of Delegates, Monday, September 30, in the Regency Ballroom of the Hyatt Regency Hotel. Any KMA member may confer with the Committee during this meeting.

The report of the Nominating Committee will be posted in the general assembly hall at the conclusion of the first general session, Tuesday morning, October 1.

Nominations may be made from the floor during the second meeting of the House of Delegates, Wednesday evening, October 2, in the Patterson Ballroom. The House will vote on the nominees at this meeting.

Members of the Committee are: Henry R. "Hank" Bell, MD, Elkton, Chairman; John D. Ammon, MD, Florence; Ralph D. Caldrony, MD, Lexington; and Marion A. Douglass, MD, Magnolia.

Nominations should be sent before the Annual Meeting to the KMA Headquarters Office, Attention, Nominating Committee.

### House to Elect New Officers During Annual Meeting

KMA officers for the 1991-92 Association year will be elected by the House of Delegates at the close of its final meeting, Wednesday evening, October 2. Officers to be elected from the state-at-large are:

Office	Year
President-Elect	1 Year
Vice President	1 Year
Delegates to the AMA	2 Years
*Donald C. Barton, MD Corbin	
*Harold L. Bushey, MD Barbourville	
Alternate Delegates to the AMA	2 Years
*Donald J. Swikert, MD Florence	
*Larry C. Franks, MD Paducah	
*Incumbent	

### Election of Trustees and Alternate Trustees

The House of Delegates will elect five District Trustees and five Alternate Trustees at its second regular meeting, Wednesday, October 2. Nominations will be made by the Delegates from the electing Districts at a meeting following the first meeting of the House on Monday, September 30.

The Nominating Committee will report at the close of the first scientific session on Tuesday, October 1. Further nominations may be made from the floor at the final meeting of the House on Wednesday evening, October 2. All nominations are considered and acted upon by the Delegates at this final meeting.

Districts electing Trustees for 3-year terms are: **2nd District** (incumbent, John W. McClellan, MD, Henderson); **7th District** (incumbent, Cecil D. Martin, MD, Carrollton); **9th District** (incumbent, Kelly G. Moss, MD, Maysville); **10th District** (incumbent, Russell L. Travis, MD, Lexington); and **13th District** (incumbent, Charles T. Watson, MD, Ashland).

Districts electing Alternate Trustees are the same as those electing Trustees. Incumbents are: Christopher R. McCoy, MD, Owensboro, 2nd District; William P. McElwain, MD, Lawrenceburg, 7th District; Don R. Stephens, MD, Cynthiana, 9th District; Thomas K. Slabaugh, MD, Lexington, 10th District; and Bruce M. Stapleton, MD, Ashland, 13th District.

Trustees in the 2nd, 10th, and 13th Districts are eligible for reelection, while the Trustees in the 7th and 9th Districts have served two full, consecutive terms and are not eligible for reelection.

Alternate Trustees in the 2nd, 7th, 9th, and 13th Districts are eligible for reelection, while the Alternate Trustee in the 10th District has also served two full, consecutive terms and is not eligible for reelection.

## Reference Committee Activity

Speakers Danny M. Clark, MD, Somerset, and C. Kenneth Peters, MD, Louisville, will assign all officers' and committees' reports and Resolutions to one of six Reference Committees at the first meeting of the KMA House of Delegates at 9:00 am, Monday, September 30. A brief session for Reference Committee Chairmen will be held at 12:00 noon, Monday in the Atlanta Room, located in the Hyatt Hotel. Any KMA member wishing to testify on any Resolution or report is urged to be present for the Reference Committee meetings which will be held at 1:30 pm, Monday, September 30, in the lower level meeting rooms in the Hyatt Hotel. These

open sessions will last at least one hour in order for all who wish to speak to be heard. Following the open hearings, the Committees will go into executive sessions to study the reports, review the testimony, and write their reports to the House.

The Committees' recommendations will be presented at the final meeting of the House, Wednesday evening, October 2, in the Patterson Ballroom, Hyatt Hotel.

Appointments to Reference Committees and Credentials Committee and Tellers are now being finalized by the Speakers.

If your society has not yet submit-

ted the name of your Delegate(s) to the Headquarters Office, you should do so immediately, as only those names recorded in the office can be considered for appointment to one of the Reference Committees and be listed as official county society representatives.

A complete listing of members who will be serving on the six Reference Committees and the location of the Reference Committee meetings will be published in the September issue of the *KMA Journal*.

Anyone desiring names of Reference Committee members before the September issue is published should contact the Headquarters Office.

*We invite you to join us in beautiful, historical  
Lexington, Kentucky for the 141st Annual Meeting  
of the Kentucky Medical Association.*

**Prevention:**

**Rx for Health Care in the 90s**

*KMA Annual Meeting · Sept 29 - Oct 3  
Hyatt Regency Hotel · Lexington, KY*



## Capsule Schedule of 1991 Annual Meeting

LC = Lexington Center

HH = Hyatt Regency Hotel

### Sunday, September 29

- 9:00 AM KMA Executive Committee Meeting
- 12:30 PM KMA Board of Trustees Meeting & Lunch

Regency Ballroom-HH  
Regency Ballroom-HH

### Monday, September 30

- 7:30 AM Registration for House of Delegates
- 7:30 AM Continental Breakfast for House of Delegates  
hosted by FCMS
- 9:00 AM First Meeting, KMA House of Delegates
- 10:00 AM Auxiliary Committee Meetings
- 12:00 NOON Luncheon, Reference Committee Chairmen
- 1:30 PM Reference Committee Meetings
- 6:00 PM KEMPAC Reception
- 7:00 PM KEMPAC Dinner

Outside Regency Ballroom-HH  
Regency Ballroom-HH  
  
Regency Ballroom-HH  
Wyandotte Room-HH  
Atlanta Room-HH  
Various Meeting Rooms-HH  
Hyatt Suite-HH  
Regency Ballroom-HH

### Tuesday, October 1

- 7:00 AM KEMPAC Board Breakfast Meeting
- 7:00 AM Maternal Mortality Committee Breakfast
- 7:45 AM Registration
- 8:15-9:00 AM Free Coffee & Danish
- 8:00-9:00 AM Reference Committee Report Signing
- 8:50 AM Opening Ceremonies, First Scientific Session
- 9:00 AM Auxiliary Fall Board Meeting
- 12:00 NOON Luncheon Meeting, Executive Committee &  
Reference Committee Chairmen
- 1:30 PM Specialty Group Sessions . . . (Seven Specialty  
Groups will meet simultaneously at this time.  
Their programs begin on page 403)

Washington Room-HH  
Atlanta Room-HH  
Registration Area-LC  
Exhibit Hall-LC  
Mary Todd Lincoln-HH  
General Sessions Area-LC  
Regency Ballroom-HH  
Atlanta Room-HH

Various meeting rooms-LC

### Wednesday, October 2

- 7:15 AM KMIC-sponsored Breakfast
- 7:45 AM Registration
- 8:15-9:00 AM Free Coffee & Danish
- 8:50 AM Second Scientific Session
- 11:50 AM President's Installation/Awards Luncheon
- 2:15 PM Specialty Group Sessions . . . (Eight Specialty  
Groups will meet simultaneously at this time.  
Their programs begin on page 405)
- 3:00 PM KMA Board of Trustees Meeting & Dinner
- 7:00 PM Second Meeting, KMA House of Delegates

Patterson Ballroom-HH  
Registration Area-LC  
Exhibit Hall-LC  
General Sessions Area-LC  
Patterson Ballroom-HH  
Various meeting rooms-LC

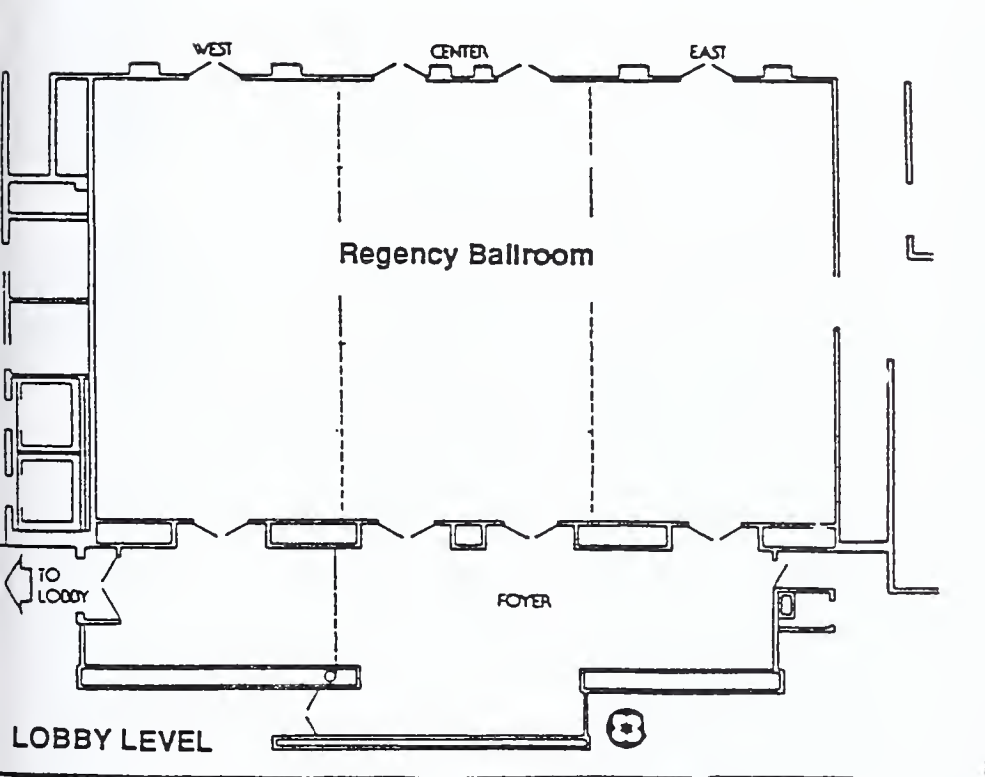
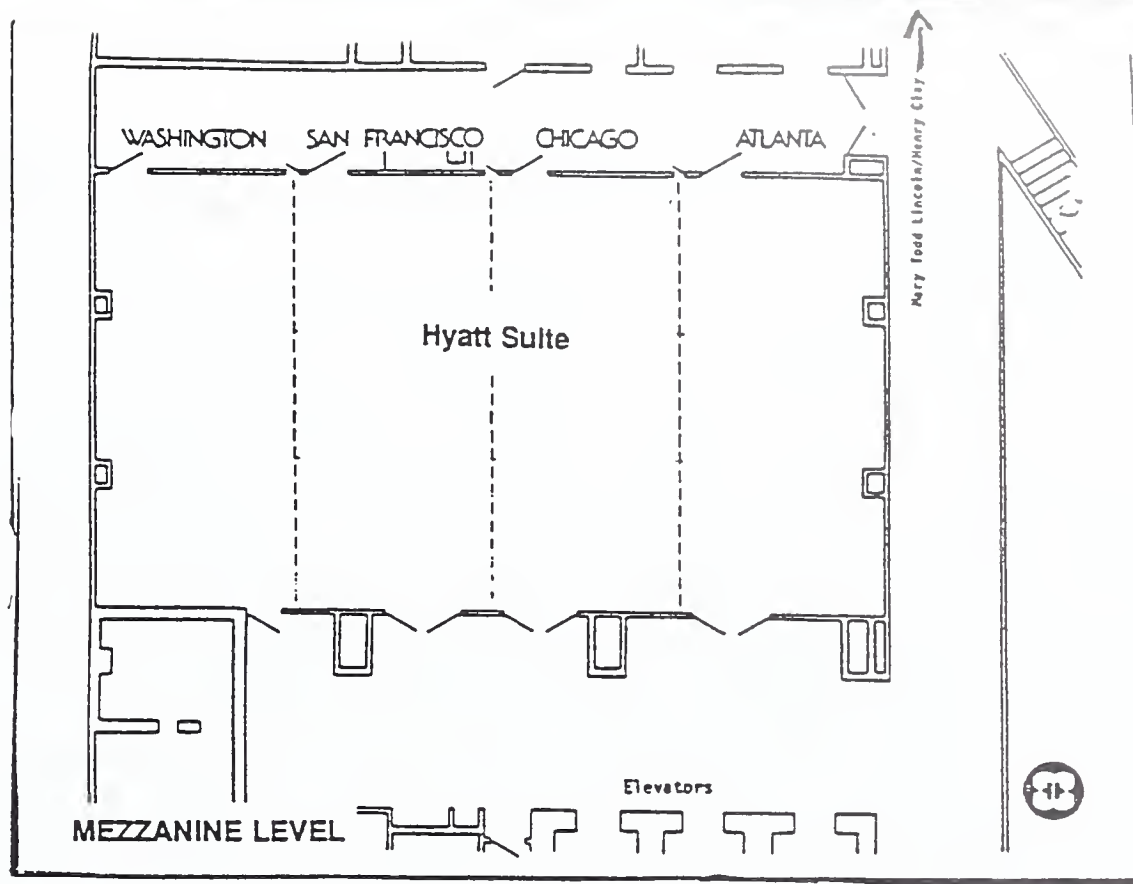
Hyatt Suite-HH  
Patterson Ballroom-HH

### Thursday, October 3

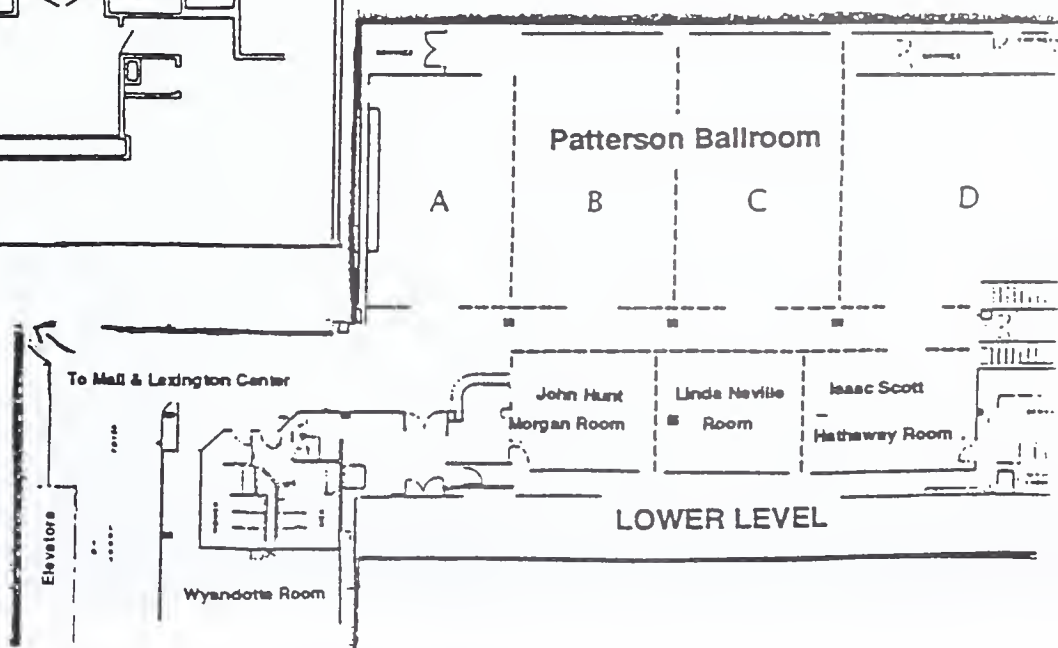
- 7:45 AM Registration
- 8:15-9:00 AM Free Coffee & Danish
- 8:50 AM Third Scientific Session
- 9:00 AM KMIC Risk Mgmt Workshop for Medical Assistants
- 12:00 NOON KMA Board of Trustees Luncheon Meeting
- 1:30 PM Specialty Group Sessions . . . (Eight Specialty  
Groups will meet simultaneously at this time.  
Their programs begin on page 407)

Registration Area-LC  
Exhibit Hall-LC  
General Sessions Area-LC  
Regency Ballroom-HH  
Hyatt Suite-HH  
Various meeting rooms-LC

*A 30-minute intermission has been scheduled during each morning Scientific Session and each afternoon Specialty Group Session for visiting Exhibits.*



## Hyatt Regency Hotel Lexington





*America's Best of Show:*

## Lexington KENTUCKY

**K**MA meeting attendees can enjoy a panorama of shopping, food, and entertainment — all within easy walking distance of your meeting.

Shopping opportunities abound in Lexington, from quaint neighborhood shopping areas to contemporary indoor malls. The unique appeal of Lexington can be found in the carousel at Festival Market, the spires of Lexington Green and the school-rooms-turned-shops at Dudley Square. Antiques, collectibles, unusual gifts, and traditional Kentucky crafts can be found throughout the city.

If you choose to stay within Lexington Center, you can enjoy the elegant, airy atmosphere of the **CIVIC**

**CENTER SHOPS.** Adjacent to Rupp Arena, the shops feature stylish clothing boutiques, gift galleries, and relaxing indoor "cafes."

Then step across the park and into another era at **VICTORIAN SQUARE.** An ambitious \$17 million restoration project brought this entire city block of turn-of-the-century buildings back to their original elegance. Inside you'll find clothiers of distinction, custom jewelers, fine confections, the finest in retail and dining establishments, including Bravo Pitino, Kentucky craft shops, and even a skylit courtyard where everything from storytelling to tea dances happen.

Connected by a skywalk to Victorian Square is **FESTIVAL MARKET,**

a glass-enclosed food and entertainment emporium that offers three dazzling levels filled with over 40 shops, restaurants, and open-air cafes. Take a spin on the musical carousel or enjoy entertainment center stage.

Just a few blocks away is **DUDLEY SQUARE,** a renovated 1800s schoolhouse that houses an array of innovative shops including antiques, prints and custom framing, collectibles, equestrian gifts, quilts and basket supplies, yarns, custom-designed needlepoint and cross-stitch, commercial and residential interiors, special-effects photography, fashions, two galleries, and Dudley's Restaurant.

Located in a historic shopping district at the corner of Euclid Avenue and High Street, **CHEVY CHASE PLAZA** sits in the heart of Lexington and houses an exceptional selection of shopping and dining, including Amato's Restaurant.

**CLAY AVENUE SHOPS,** located off East Main, houses a unique collection of shops in a former residential area developed in the 1900s. Custom stationery, children's fashions, miniatures, crafts, hobby materials, yarn, needlework, games and classroom supplies, antiques and collectibles, and a soccer shop are a few of the discoveries you will find here.

After the sun goes down, you'll find that downtown nightlife abounds from cozy little pubs to electrifying dance clubs featuring rock, jazz, bluegrass, country, and much more.

Be sure and make plans now — if you haven't already — to attend your 1991 KMA Annual Meeting in beautiful downtown Lexington. **kma**



# Annual Meeting Special Features

## Prevention: Rx for Health Care in the 90s

*KMA Annual Meeting · Sept 29 - Oct 3*  
*Hyatt Regency Hotel · Lexington, KY*

### 1991 Annual Meeting Honors Past President James Given Carpenter, MD

The 1991 Annual Meeting of the Kentucky Medical Association will be officially titled "The James Given Carpenter Meeting" in remembrance of the 1911 President of the Association. The tradition of honoring a past president of KMA and other distinguished physicians originated with the 1935 Annual Meeting. Eugene H. Conner, MD, Louisville, KMA Historian, has written a biography on Dr Carpenter that begins on page 401.

**Scientific Sessions** are scheduled for October 1, 2, & 3 at the Lexington Center in Lexington. The theme for the 1991 scientific session is "Prevention: Rx for Health Care in the 90s." Both the presentations and discussion periods will contribute to the continuing medical education of Kentucky's physicians.

**Twenty-three Specialty Groups** will hold meetings on the afternoons of October 1, 2, & 3. Beginning at 1:30 pm on Tuesday and Thursday and 2:15 pm on Wednesday, they will be held in the meeting rooms located in the Lexington Center. Individual programs of specialty societies are listed in this issue. All general sessions will be held in the mornings. Specialty groups will meet all three afternoons with no general sessions scheduled during these specialty group meetings. All KMA members are invited to attend any specialty meetings.

**Scientific and Technical Exhibits** will display new medical products, services and techniques in the Exhibit Hall, located in the Lexington Center during the 1991 Annual Meeting. Members and guests are urged to take the opportunity to view products of interest at the 30-minute intermissions scheduled during each general and specialty session.

**The KMA House of Delegates** will meet twice during the Annual Meeting. The first meeting of the House will be held at 9:00 am, Monday, September 30, in the Regency Ballroom located in the Hyatt Hotel. The final meeting will be held Wednesday, October 2, at 7:00 pm, in the Patterson Ballroom. Officers for the 1991-92 Associational year will be elected at the second meeting.

**The President's Installation & Awards Luncheon** will be held on Wednesday, October 2, in the Patterson Ballroom located in the Hyatt Hotel. The luncheon will include the presentation of KMA awards and the installation of the 1991-92 President, S. Randolph Scheen, MD, Louisville.



# KEMPAC

## 29th Annual Seminar-Banquet

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*Gubernatorial Candidates*

Larry J. Hopkins  
Brereton C. Jones

*have been invited as  
our special guests to  
address the seminar*

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Monday, September 30, 1991  
6 PM EDT — Reception — Hyatt Suite  
7 PM EDT — Dinner — Regency Ballroom  
(Program to Follow Dinner)  
Hyatt Regency Hotel  
Lexington, KY



J. G. CARPENTER  
1911

## James Given Carpenter, MD 1854-1942

**A**t the 56th Annual Meeting of the Kentucky Medical Association, 24 October 1911, in Paducah, James Given Carpenter, MD, of Stanford, Lincoln County, assumed its presidency. He had been chosen President-Elect at the Annual Meeting in Lexington on 28 September 1910.<sup>1</sup> He was well known throughout the state for his work on behalf of the medical profession, the state, regional, and county medical societies, and for his untiring efforts in the support of the public health movement.

Born in Hustonville, Lincoln County, Kentucky, on 24 August 1854, the son of Hugh Logan and Elizabeth Morrison (Bright) Carpenter, young James attended both public and private schools. Graduating from Christian College, Hustonville, he obtained his teaching certificate after attending Professor Burdette Myer's school in Stanford. He taught school from 1871 until December 1872 when he began his medical preceptorship at Stanford under a kinsman, Pleasant Woods Logan, MD.<sup>2</sup>

In the fall of 1873, Carpenter matriculated, along with 262 others, for his first course of medical lectures at the Louisville Medical College, Louisville, Kentucky.<sup>3</sup> The following year he matriculated at the Medical Department of

the University of the City of New York from which he received his MD in February 1875.

Carpenter began practice in Stanford, but after 5 months moved to Crab Orchard Springs in eastern Lincoln County. Here he met Lillie B. Fish and they married 13 December 1877. To them were born four children: Lillie Tevis, James Given, Jr, Hubert Craig, and Josephine Price. Early in February 1882, he moved his family to Stanford. Lillie died in 1919. Three years later (March 1922) Doctor Carpenter married Miss Lucie Beasley. He maintained his residence in Stanford until his death in Louisville on 7 October 1942, at age 88.<sup>4, 5</sup>

Doctor Carpenter was a firm believer in continuing post-graduate education and the important role of the medical society as a means for continuing one's medical education as both teacher and pupil. He availed himself of institutionalized post-graduate training in ear, nose and throat under Thomas P. Rumbold of St. Louis, Missouri, in 1881, 1884, and 1885; ophthalmology, histology, and pathology at NY Polyclinic, 1889; private instruction in abdominal and pelvic surgery under Joseph Price, MD (1853-1911), Philadelphia, 1889, and for a 3-months course

in 1892-1893; ophthalmology 3-months course at Philadelphia Polyclinic, 1892-1893.<sup>6</sup>

Although he never held an academic appointment and published almost nothing, Joseph Price was a great surgeon and taught a host of post-graduate students from several private hospitals. Doctor Carpenter considered him his preceptor, mentor, and lifelong friend. Carpenter maintained a Philadelphia connection for sometime, serving on the Board of Censors of the Medico-Chirurgical College and Hospital of Philadelphia (1894-1910?). He named one of his children after Doctor Price and also the first hospital in Stanford — The Joseph Price hospital, having 16 beds and a nurses' training school, established in partnership with J. F. Peyton, MD, on 1 August 1895.

For his day and time, Doctor Carpenter was unusually well-trained in eye, ear, nose and throat, general and pelvic surgery, and pathology. He had a well-disciplined mind and took time to share his experiences with others by addressing medical societies and contributing papers for publication. In his later years he continued to publish biographical sketches and/or memorials of his contemporaries and even a case report at age 81!<sup>7</sup> His papers appeared in *The*



*Saint Louis Medical and Surgical Journal, Gaillard's Medical Journal, American Practitioner and News, Southern Medical Journal, JAMA, Transactions KMA, Kentucky State Medical Journal, and Cincinnati Lancet.* At one time he gave a series of lectures on gynecology and gynecologic surgery at Barnes Hospital Medical College, St. Louis, Missouri.<sup>8</sup>

Carpenter was the first physician to illuminate the interior of the sigmoid colon for purposes of diagnosis and treatment. He chemically cauterized (AgNO<sub>3</sub>) several ulcerated lesions and effected a cure. First performed on 30 November 1885, he presented his technique and results of treatment during the KMA Annual Meeting at Winchester, 23-25 June 1886. His address was published in the *American Practitioner and News*, August 1886.<sup>9</sup> Carpenter's priority in this discovery was acknowledged by the section on surgery of the AMA on 18 May 1896, and by his only contender, Howard A. Kelly, MD (1858-1943).<sup>10, 11</sup>

Carpenter continued to present the importance of medical society meetings as effective means of physicians teaching one another. At regularly scheduled medical society meetings where, as often as possible, lectures and case presentations were supplied by the members, he was able to convince colleagues that continuing education was essential, possible, and practical. Apparently he did not overlook the importance of unstructured discussions within a social context before and after the meetings.

By helping to organize and actively serving in various leadership capacities, Carpenter emphasized his own belief in the importance of the medical society. He was founder of numerous professional societies: The American Rhinological Society (Founder and Fellow); the Central Kentucky Medical Society (Vice President, 1882; President, 1892); Southeastern Kentucky Medical Society (President); Russell Springs Medical Society (with Joshua T. Wesley, MD, and his son, Isaac Wesley, MD, of Casey County); and Casey County Med-

ical Society (Honorary Member). He was an active participant in older medical societies: Mississippi Valley Medical Society, Kentucky State Medical Association, and American Medical Association (Delegate, 1884, 1890, 1891, 1896, 1897). He was also a longtime member of the Crab Orchard Literary Society.<sup>12</sup>

In addition to serving in these medical societies, Carpenter was a Lincoln County Health Officer for 25 years and Chairman of Lincoln County Board of Health (1883-1884). He also served as Counsellor in the KMA and as a Stanford Councilman, 1887-1891.

Doctor Carpenter was always interested in new techniques that would benefit the patient. In one instance, he did misjudge the safety and effectiveness of a technique of stretching the sciatic nerve for treatment of sciatica and nerve stretching in the treatment of the spasms of traumatic tetanus; however, he ultimately recognized its shortcomings.<sup>13</sup>

Almost always focusing his attention on the betterment of the health of Kentuckians, as President-Elect of KMA, he is said to have made over two dozen lectures on tuberculosis and sanitary science to lay groups throughout the state. In his presidential address he urged his professional colleagues to elect men to the legislature who would give proper consideration to the health measures proposed by the physicians of the state. He suggested, too, that physicians demand state and county tuberculosis hospitals. Not limiting his vision to measures affecting Kentucky, he sought to have established a US Department of Health with a Secretary in the US President's Cabinet.<sup>14</sup>

For Doctor Carpenter only one hobby filled the small respites of a very busy professional life. This was his 1,050 acre bluegrass farm which he called his "Kentucky Ranch." Here he raised a prize Jersey milk herd widely known for the high butterfat content of their milk.<sup>15</sup> In addition to the dairy herd, he kept fine horses as he continued to ride horseback and make his rounds in a buggy hitched to an elegant trotter. He

used an automobile only in emergencies.

Doctor Carpenter was a communicant of the Christian Church, but more importantly, he was serious about his Christian tenets and lived by the golden rule.

James Given Carpenter, MD, was a vigorous farsighted physician who was devoted to his patients, his colleagues, and his fellow citizens. A memorial meeting honoring him for his service over 80 years ago is an appropriate reminder that his work and contributions were not in vain and should serve to inspire us to strive to his greatness.

**Eugene H. Conner, MD**

## References

1. Carpenter JG. President's Address "United we stand, divided we fall." *JKMA* 10, 8-14, 1912.
2. Johnson E. Polk, *A History of Kentucky and Kentuckians* . . . , 3 vols. The Lewis Publishing Co, Chicago and NY, 1912. 2, 845-847.
3. *Mss Matriculation Book Louisville Medical College, 1869-70 to 1882-83*. p. 48. Original in Kornhauser HS Library, UL, Louisville.
4. Obituary: Doctor JG Carpenter, *KMJ*, 40, 429, 1942.
5. Obituary: *JAMA*, 120, 782, 1942.
6. Vide supra #2. p 846.
7. Carpenter JG. Infantile Paralysis. Report of care treated with Rosenow Serum. *KMJ* 33, 579-580, 1935.
8. Transcript in WPA Medical History files, Kornhauser HS Library, UL, Louisville, KY. Attributed to a pamphlet identified only by title *Physicians and Surgeons of America*.
9. Carpenter JG: Ulceration of the Sigmoid Flexure. Inversion of the Trunk, Electric and Reflected Light in Diagnosis and Treatment. *American Practitioner and News* n.s. 2, 130-134, 1886.
10. Letter from JG Carpenter, MD, Stanford, KY dated 16 October 1896 to Howard A. Kelly, MD, Baltimore, MD. Copy in Historical Collections, Kornhauser HS Library, UL, Louisville, KY.
11. AMA Section on Surgery and Anatomy at meeting in Atlantic City, NJ, 5-8 May 1896. JG Carpenter declared author of sigmoidoscopy. *JAMA*, 26, 793, 1896.
12. Vide supra #2, p 847.
13. Carpenter JG: The Pathology and Treatment of Chronic Sciatica, *JAMA*, 13, 365-370, 1889.
14. Vide supra #1, pp 9-10.
15. He calls himself a "Hill Billy" Doctor, yet he rates way up in his profession. *The Herald-Post*, New Kentucky edition, Thursday, October 8, 1925. Sect. 10, p 10, cols 6-8, cont'd p 14, cols 6-8.

# Prevention:

## Rx for Health Care in the 90s

Kentucky Medical Association

## Scientific Program

James Given Carpenter Meeting

### Preston P. Nunnelley, MD KMA President, Presiding

Tuesday, October 1, 1991  
Morning General Session  
Ballroom 4 — Lexington Center

- 8:50 AM Opening Ceremonies
- 9:00 AM **"Pap Smear Screening — The Bethesda Reporting System"**  
Robert C. Park, MD, Washington, DC
- 9:20 AM **"Recent Advances in the Use of PSA in Prostate Cancer"**  
Paul H. Lange, MD, Seattle, WA
- 9:40 AM **"Evaluation and Management of Ventricular Arrhythmias: A Post C.A.S.T. Analysis"**  
N. A. Mark Estes, III, MD, Boston, MA
- 10:00 AM **Intermission to Visit Exhibits**
- 10:30 AM **"Cancer Prevention Strategies"**  
Walter Lawrence, Jr, MD, Richmond, VA
- 10:50 AM **"The Road to the Prevention of Type I Diabetes"**  
William J. Riley, MD, Gainesville, FL
- 11:10 AM **"Preventing Suicide in Your Elderly Patients"**  
Sanford I. Finkel, MD, Chicago, IL
- 11:30 AM **"Low Back Pain: A New Look at an Old Problem!"**  
Barth A. Green, MD, Miami, FL

### Ky OB/GYN Society — Ky Section ACOG

Ballroom 2  
Lexington Center  
Tuesday, October 1, 1991

- 1:00 PM Business Meeting
- 1:30 PM **"Approach to the Undiagnosed Adnexal Mass"**  
Robert C. Park, MD, Washington, DC
- 2:00 PM **"Prevention of Preterm Labor"**  
Stanley A. Gall, MD, Louisville, KY
- 2:30 PM **"Prevention of Preeclampsia"**  
Susan M. Cox, MD, Lexington, KY
- 3:00 PM **Intermission to Visit Exhibits**
- 3:30 PM **"Detection of Intrauterine Abnormalities"**  
Joseph A. Spinnato, MD, Louisville, KY
- 4:00 PM **"Preconception Counseling"**  
Steve N. London, MD, Lexington, KY

### Ky Urological Association

Meeting Room D  
Lexington Center  
Tuesday, October 1, 1991

- 1:30 PM **"Continent Urinary Reservoirs: What, When and How?"**  
Paul H. Lange, MD, Seattle, WA
- 3:00 PM **Intermission to Visit Exhibits**
- 3:30 PM **"Pyelogram Hour"**



## Ky Chapter, American College of Chest Physicians

Meeting Room C  
Lexington Center  
Tuesday, October 1, 1991

- 1:30 PM **"Evaluation and Management of Ventricular Arrhythmia: A Post C.A.S.T. Analysis"**  
N. A. Mark Estes, III, MD, Boston, MA
- 2:15 PM **"A.C.E. Inhibitors — Many Roles"**  
To Be Announced
- 3:00 PM **Intermission to Visit Exhibits**
- 3:30 PM **"Thrombolytic Therapy"**  
To Be Announced
- 4:15 PM **"Pleural Disease"**  
Steven Sahn, MD, Charleston, SC
- 7:00 PM **Dinner — Hyatt Hotel-Mezzanine Level**  
Washington/San Francisco Rooms

## Ky Chapter, American College of Surgeons

Ballroom 4 — General Sessions Area  
Lexington Center  
Tuesday, October 1, 1991

- 1:30 PM **"Kentucky Cancer Registry"**  
Gilbert H. Friedell, MD, Lexington, KY
- 2:00 PM **"Management of Soft Tissue Sarcoma"**  
Walter Lawrence, Jr, MD, Richmond, VA
- 2:30 PM **"Socioeconomic Issues — Update From the American College of Surgeons"**  
Paul A. Ebert, MD, Chicago, IL
- 3:00 PM **Intermission to Visit Exhibits**
- 3:30 PM **"Advances in Vascular Surgery"**  
Thomas H. Schwarcz, MD, Lexington, KY
- 4:00 PM **"Rural Trauma System Development"**  
Paul A. Kearney, MD, Lexington, KY

## Ky Psychiatric Association

Meeting Rooms A & B  
Lexington Center  
Tuesday, October 1, 1991

- 1:00 PM **"Depression"**  
Sanford I. Finkel, MD, Chicago, IL
- 2:00 PM **General Business Meeting**
- 2:30 PM **Panel Discussion — "Managed Care"**
- 4:00 PM **Intermission to Visit Exhibits**
- 4:30 PM **Barry Bingham Media Award Reception**

## Ky Pediatric Society

Ballroom 3  
Lexington Center  
Tuesday, October 1, 1991

- 1:30 PM **"New Trends in Attention Deficit Hyperactivity Disorder"**  
Judith A. Axelrod, MD, Louisville, KY
- 1:50 PM **"What's New in Inflammatory Bowel Disease?"**  
Robert Dillard, MD, Lexington, KY
- 2:10 PM **"Kawasaki Disease — Treatment Update"**  
Walter Sobczyk, MD, Louisville, KY
- 2:30 PM **"RDS and Artificial Surfactant — A Breakthrough?"**  
Lori A. Shook, MD, Lexington, KY
- 2:50 PM **Intermission to Visit Exhibits**
- 3:20 PM **"Progress Towards Prevention and Cure of Type I Diabetes by Immunosuppression"**  
William J. Riley, MD, Gainesville, FL
- 4:00 PM **Discussion**

## Ky Neurosurgical Society

Meeting Rooms E & F  
Lexington Center  
Tuesday, October 1, 1991

- 1:30 PM **"Caspar Instrumentation in Degenerative Disorders of the Cervical Spine"**  
Phillip A. Tibbs, MD, Lexington, KY  
Marcus P. Schmitz, MD, Lexington, KY
- 1:45 PM **"Focal Spondylotic Mid-Cervical Spinal Cord Compression Manifested in Distal Segmental Symptoms and Signs"**  
Bothwell G. Lee, MD, Louisville, KY
- 2:00 PM **"Evaluation and Treatment of Cervical Fractures and Current Research on Spinal Cord Injury"**  
Barth A. Green, MD, Miami, FL
- 2:45 PM **Intermission to Visit Exhibits**
- 3:15 PM **"A Portable Traction for Immobilizing Cervical Fractures"**  
Richard K. Jelsma, MD, Louisville, KY
- 3:30 PM **"Channel Vertebroctomy With and Without Dorsal Stabilization"**  
David G. Changaris, MD, Louisville, KY
- 3:45 PM **"Far Lateral Ruptured Lumbar Discs"**  
Andrieus J. Dzenitis, MD, Louisville, KY
- 4:00 PM **"Atherosclerotic Carotid Artery Lesions — Noninvasive Assessment"**  
Robert J. Dempsey, MD, Lexington, KY
- 4:15 PM **Business Meeting**

**Sonia R. Teller, MD**  
**Chairperson**  
**Scientific Program Committee**  
**Presiding**

Wednesday, October 2, 1991  
 Morning General Session  
 Ballroom 4  
 Lexington Center

- 8:50 AM Announcements  
 9:00 AM **"The Physician's Role in Ending the Tobacco Pandemic"**  
 Alan Blum, MD, Houston, TX  
 9:40 AM **"Prevention of Malpractice in the Emergency Room Setting"**  
 Neal Little, MD, Ann Arbor, MI  
 10:00 AM **"Screening/Quality Assurance in Cytology"**  
 Barbara F. Atkinson, MD, Philadelphia, PA  
 10:20 AM **Intermission to Visit Exhibits**  
 10:50 AM **To Be Announced**  
 11:10 AM **"The Psychodynamics of Plastic Surgery"**  
 Milton T. Edgerton, MD, Charlottesville, VA  
 11:30 AM **"Prevention and Quality Improvement Opportunities in Occupational Medicine"**  
 Jeffrey S. Harris, MD, Nashville, TN  
 11:50 AM **PRESIDENT'S LUNCHEON**

**President's Installation & Awards Luncheon**

Patterson Ballroom  
 Hyatt Regency Hotel

**Preston P. Nunnelley, MD**  
**KMA President, presiding**

Invocation  
 Recognition

**Awards Presentation**

**Nelson B. Rue, MD, Bowling Green**  
**Chairman, KMA Awards Committee**  
**Installation of new KMA President**

**Ky Chapter, American Academy of Family Physicians**  
**Ky Association of Public Health Physicians**

Ballroom 4 — General Sessions Area  
 Lexington Center  
 Wednesday, October 2, 1991

- 2:15 PM **"A History and Outlook For Doctors Ought to Care"**  
 Alan Blum, MD, Houston, TX  
 3:30 PM **Intermission to Visit Exhibits**  
 4:00 PM **Ky Chapter, American Academy of Family Physicians**  
 Business Meeting — Ballroom 4 —  
 Lexington Center  
**Ky Association of Public Health Physicians**  
 Business Meeting — Meeting Room F —  
 Lexington Center

**Ky Chapter, American College of Emergency Physicians**

Meeting Room B  
 Lexington Center  
 Wednesday, October 2, 1991

- 2:15 PM **"Prevention of Malpractice in the Emergency Department"**  
 Neal Little, MD, Ann Arbor, MI  
 3:00 PM **Intermission to Visit Exhibits**  
 3:30 PM **"Prevention of Malpractice in the Emergency Department"**  
 Neal Little, MD, Ann Arbor, MI

**Ky Society of Pathologists**

Meeting Room C  
 Lexington Center  
 Wednesday, October 2, 1991

- 2:15 PM **"Pap Smears: The Bethesda System and C.L.I.A."**  
 Barbara F. Atkinson, MD, Philadelphia, PA  
 3:15 PM **Intermission to Visit Exhibits**  
 3:45 PM **"Pap Smears: The Bethesda System and C.L.I.A."**  
 Barbara F. Atkinson, MD, Philadelphia, PA



## Ky Chapter, American College of Physicians

Ballroom 3  
Lexington Center  
Wednesday, October 2, 1991

2:15 PM **To Be Announced**

## Ky Society for Plastic and Reconstructive Surgery

Meeting Room D  
Lexington Center  
Wednesday, October 2, 1991

2:15 PM **"Advances in Craniofacial Surgery—Challenges in Soft Tissue Reconstruction"**

Milton T. Edgerton, MD, Charlottesville, VA

2:30 PM **"Recent Progress in the Lateral Arm Free Flap"**

Robert D. Acland, MD, Louisville, KY

2:40 PM **"Clinical Applications of Growth Factors"**

Greg L. Brown, MD, Louisville, KY

2:50 PM **"Microsurgical Experiences in Head and Neck Reconstruction"**

Henry C. Vasconez, MD, Lexington, KY

3:00 PM **"Microsurgical Update: Recent Advances"**

John W. Derr, MD, Louisville, KY

3:10 PM **"Plastic Surgery in the Third World"**

Timothy K. Hulsey, MD, Bowling Green, KY

3:20 PM **To be Announced**

University of Kentucky Resident

3:30 PM **To be Announced**

University of Louisville Resident

3:40 PM **To be Announced**

University of Kentucky Resident

3:50 PM **To be Announced**

University of Louisville Resident

4:00 PM Problem Case Discussion

## Ky Occupational Medical Association

Meeting Room E  
Lexington Center  
Wednesday, October 2, 1991

2:15 PM **"Closed Spaces"**

Geoffrey Kelafant, MD, Lexington, KY

2:35 PM **"Arsenic Poisoning"**

Chaim Cohen, MD, Lexington, KY

2:55 PM **Additional Comments from Morning Session**

Jeffrey S. Harris, MD, Nashville, TN

3:15 PM **Intermission to Visit Exhibits**

4:15 PM **"Vibrometric Analysis of Peripheral Neuropathy"**

Daniel Wolens, MD, Lexington, KY

4:45 PM KOMA Business Meeting

## Ky Academy of Physical Medicine and Rehabilitation

Meeting Room A  
Lexington Center  
Wednesday, October 2, 1991

2:30 PM Annual Business Meeting

3:30 PM **"Physician Assistant Roles in Rehabilitation Medicine"**

Richard Salcido, MD, Lexington, KY

4:00 PM **Intermission to Visit Exhibits**

4:15 PM **"P.M. & R. in the 21st Century"**

Leon Reinstein, MD, Baltimore, MD

The Kentucky Medical Association is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education for physicians.

## William B. Monnig, MD KMA Vice President, Presiding

Thursday, October 3, 1991  
Morning General Session  
Ballroom 4  
Lexington Center

- 8:50 AM Announcements  
9:00 AM **"The Importance of Altering Cardiovascular Risk Factors in Elderly Persons"**  
William B. Applegate, MD, Memphis, TN  
9:20 AM **"New Strategies in the Preventive Care for Asthma"**  
Thomas F. Smith, MD, Atlanta, GA  
9:40 AM **"Skin Cancer Prevention and Treatment"**  
Stuart J. Salasche, MD, Boston, MA  
10:00 AM **"Preventing Vision Loss: Diabetes 2000"**  
George W. Weinstein, MD, Morgantown, WV  
10:20 AM **Intermission to Visit Exhibits**  
10:50 AM **"Low Back Pain: Newer Insights into a Longstanding Problem"**  
Dan M. Spengler, MD, Nashville, TN  
11:10 AM **"Occult Blood: A Flawed Screening Marker for Colorectal Cancer"**  
David A. Ahlquist, MD, Rochester, MN  
11:30 AM **"The Prevention of Anesthetic Mishaps"**  
Richard L. Keenan, MD, Richmond, VA  
11:50 AM **"Laryngeal Cancer: How Current Treatment Strategies Can Eliminate the Loss of Speech"**  
Bruce W. Pearson, MD, Jacksonville, FL

## KMA Medical Student Section & KMA Resident Physician Section

Patterson Ballroom B  
Lower Level  
Lexington Conference Center  
Thursday, October 3, 1991

- 10:00 AM Welcome — Presidents of the two Sections  
10:10 AM Welcome from KMA  
10:20 AM **Resident Work Hours**  
Ward Griffen, MD, Executive Director  
American Board of Surgery, Philadelphia  
AMA-RPS Representative  
11:20 AM Questions & Answers  
11:30 AM **National Legislative Issues**  
Sharon Swan, AMA-MSS Policy Analyst  
12 NOON Adjournment

## Ky Geriatrics Society

Meeting Room C  
Lexington Center  
Thursday, October 3, 1991

- 1:30 PM **Keynote Address**  
William B. Applegate, MD, Memphis, TN  
2:30 PM **"Subtle Presentation of Infectious Disease in the Elderly"**  
Christine Tully, MD, Lexington, KY  
3:00 PM **Intermission to Visit Exhibits**  
3:30 PM **"Managing Behavioral Problems"**  
John C. Wright, II, MD, Louisville, KY  
4:00 PM **KGS Business Meeting**  
S. Philip Greiver, MD, President, Louisville, KY  
5:15 PM Reception  
6:00 PM Dinner

## Ky Society of Allergy and Clinical Immunology

Meeting Room D  
Lexington Center  
Thursday, October 3, 1991

- 1:30 PM **"Antiasthma Drugs on the Horizon"**  
Thomas F. Smith, MD, Atlanta, GA  
2:15 PM **"Occupational Asthma"**  
Tobias Enright, MD, Louisville, KY  
3:00 PM **Intermission to Visit Exhibits**  
3:30 PM **"Basophil Histamine Release in Young Children"**  
Angela Duff, MD, Charlottesville, VA  
4:15 PM **"Bird Fancier's Disease: Case Report"**  
Mark L. Corbett, MD, Louisville, KY

## Ky Dermatological Society

807 S. Limestone Street  
Lexington, Kentucky  
Thursday, October 3, 1991

- 2:00 PM **Patient Presentations**  
Offices of Doctors  
Leavell, Mersack, Davey, and Guiglia  
3:00 PM **Intermission to Visit Exhibits**  
3:30 PM **Patient Discussion**  
Offices of Doctors  
Leavell, Mersack, Davey, and Guiglia  
6:30 PM Dinner  
Spindletop Restaurant



## Ky Academy of Eye Physicians and Surgeons

Ballroom 4 — General Sessions Area  
Lexington Center  
Thursday, October 3, 1991

- 1:30 PM **"Diabetes 2000: AAO Perspective"**  
George W. Weinstein, MD, Morgantown, WV
- 2:00 PM **"Diabetic Maculopathy"**  
Robert Murphy, MD, Baltimore, MD
- 2:30 PM **Intermission to Visit Exhibits**
- 3:00 PM **"Diabetic Maculopathy"**  
Robert Murphy, MD, Baltimore, MD
- 3:30 PM **KAEPS Member**
- 3:45 PM **KAEPS Member**
- 4:00 PM **Business Meeting**  
John Reeves, MD, President, Erlanger, KY
- 5:00 PM **Reception**

## Ky Orthopaedic Society

Meeting Rooms E & F  
Lexington Center  
Thursday, October 3, 1991

- 1:30 PM **"Revision Total Knee Arthroplasty Using the Insall Bernstein CCK System"**  
Jeffrey W. Parr, MD, Lexington, KY  
Eugene Q. Parr, MD, Lexington, KY
- 1:50 PM **"Modified Reverdin Osteotomy for Hallux Valgus and Bunion Disorder"**  
Martin G. Schiller, MD, Louisville, KY
- 2:10 PM **"Clinical Radiographic and Pedobarographic Analysis After Unilateral Hallux Amputation"**  
George E. Quill, Jr, MD, Louisville, KY
- 2:30 PM **Intermission to Visit Exhibits**
- 3:00 PM **"Internal Fixation of the Lumbar Spine, Indication, Advantages, and Complications"**  
Dan M. Spengler, MD, Nashville, TN
- 3:40 PM **"Pedicle Screw Fixation for Lumbar Spine Instability"**  
H. Brooks Morgan, MD, Lexington, KY
- 4:00 PM **"A New Way to Use Identifit Technology in Total Hip Arthroplasty"**  
Ernest A. Eggers, MD, Louisville, KY
- 4:20 PM **"Modified Technique for Lateral Ankle Reconstruction"**  
Alexander Pruitt, MD, Elizabethtown, KY
- 4:40 PM **"Medial Approach for Surgical Reduction in CDH"**  
Thomas M. Loeb, MD, Louisville, KY  
Leonard A. Goddy, MD, Louisville, KY
- 5:00 PM **Business Meeting**  
Scott B. Scutchfield, MD, President, Danville, KY
- 6:30 PM **Reception — Dinner**  
Lafayette Club

## Ky Society for Gastrointestinal Endoscopy

Ballroom 2  
Lexington Center  
Thursday, October 3, 1991

- 1:30 PM **"Endoscopic Management of Colorectal Neoplasia"**  
David A. Ahlquist, MD, Rochester, MN
- 2:30 PM **Intermission to Visit Exhibits**
- 3:00 PM **"Incidence and Type of Infections in Patient Calorie Malnutrition"**  
David Lee, MD, and Steve A. McClave, MD, Louisville, KY
- 3:10 PM **"Experience with Percutaneous Endoscopic Jejunostomy"**  
Joseph M. Henderson, MD; Walter E. Profahl, MD; Thomas N. Zweng, MD; William E. Strodel, MD; and Norman H. Gilinsky, MD, Lexington, KY
- 3:20 PM **"Techniques for Endoscopic Suture Removal"**  
Kurtis W. Martin, MD; Thomas N. Zweng, MD; and William E. Strodel, MD, Lexington, KY
- 3:30 PM **"Role of Biliary Endoscopy and Laparoscopic Cholecystectomy"**  
Gerald R. Larson, MD, Louisville, KY
- 3:40 PM **"Volvulus of the Colon"**  
Chris J. Theuer, MD, and William G. Cheadle, MD, Louisville, KY
- 3:50 PM **"Pulse Oximetry and Hemodynamic Monitoring During PEG/PEJ"**  
Ellen B. Morlote, MD; Thomas N. Zweng, MD; and William E. Strodel, MD, Lexington, KY
- 4:00 PM **"Maloney Dilatation — Fluoroscopic vs Blinded Technique. Use of Barium Pill Passage as Clinical Endpoint"**  
Steve A. McClave, MD, Louisville, KY
- 4:30 PM **KSGE Annual Meeting and Election (Members Only)**
- 5:00 PM **Cocktails and Awards**

**Ky Society of Anesthesiologists**

Ballroom 3

Lexington Center

Thursday, October 3, 1991

- 1:00 PM **"Anesthesia Outcome Studies: What We Have Learned"**  
Richard L. Keenan, MD, Richmond, VA
- 1:45 PM **"The Perioperative Management of Hypertension and Its Anesthetic Implications"**  
John Leslie, MD, Durham, NC
- 2:30 PM **Intermission to Visit Exhibits**
- 3:00 PM **To be Announced**
- 3:45 PM **"Total Intravenous Anesthesia (TIVA) — The Drugs"**  
Paul F. White, MD, St. Louis, MO
- 4:30 PM **"Quality Assurance in Anesthesia"**  
Michael F. Heine, MD, Louisville, KY
- 5:15 PM **Panel Discussion**

**Ky Society of Otolaryngology Head and Neck Surgery, Inc.**

Meeting Rooms A &amp; B

Lexington Center

Thursday, October 3, 1991

- 1:30 PM **"Preserving Cerebral Blood Flow: Potential Carotid Artery Complications; Avoidance During Head and Neck Surgery"**  
Bruce W. Pearson, MD, Jacksonville, FL
- 2:00 PM **"Modification of Neck Dissections"**  
Bruce W. Pearson, MD, Jacksonville, FL
- 2:45 PM **Intermission to Visit Exhibits**
- 3:00 PM **"Overview of Squamous Cell Carcinoma of Larynx. Five Stages — Treatment and Limitations"**  
Bruce W. Pearson, MD, Jacksonville, FL
- 4:00 PM **Intermission to Visit Exhibits**
- 4:15 PM **"Subtotal Laryngectomy — Complication Management — Update on Results"**  
Bruce W. Pearson, MD, Jacksonville, FL
- 4:30 PM **"Discussion on Results in Kentucky: Its Place Outside Mayo Clinic"**  
Bruce W. Pearson, MD, Jacksonville, FL

**CONTINUING  
MEDICAL  
EDUCATION**

*The Kentucky Medical Association designates this continuing medical education activity for 17.0 credit hours in Category 1 of the Physician's Recognition Award of the American Medical Association. One credit hour may be claimed for each hour of participation by the individual physician.*

**CME  
AMERICAN ACADEMY OF  
FAMILY PHYSICIANS**

*This program has been reviewed and is acceptable for 16.5 prescribed hours by the American Academy of Family Physicians.*



## Introducing the Annual Meeting Speakers



**Barth A. Green, MD**  
Miami, FL

Professor, Department of Neurological Surgery, and Professor, Orthopaedics and Rehabilitation, University of Miami School of Medicine. MD, 1969, Indiana University School of Medicine, Indianapolis. Diplomate, American Board of Neurological Surgery. Member, American Association of Neurological Surgeons; Congress of Neurological Surgeons; and Fellow, American College of Surgeons. Editorial Board, *Paraplegia*; *Journal of the International Medical Society of Paraplegia*; and *Journal of CNS Trauma*.



**Walter Lawrence, Jr, MD**  
Richmond, VA

Health Sciences Division, Department of Surgery, Division of Surgical Oncology, Medical College of Virginia, Richmond. MD, 1948, University of Chicago School of Medicine. Member, Royal Society of Medicine; Past President, Society of Surgical Oncology; and Fellow, American College of Surgeons. Editorial Board, *Journal of Cancer Education*.



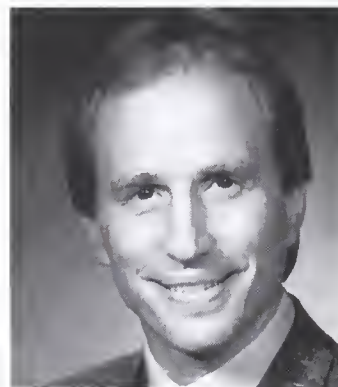
**Robert C. Park, MD**  
Washington, DC

Department of OB-GYN, Department of the Army, Walter Reed Army Medical Center, Washington. MD, 1958, Hahnemann Medical College, Philadelphia. Member, Society of Gynecologic Oncologists and International Gynecologic Cancer Society; Charter Member, Society of Gynecologic Surgeons. Fellow and Past President, American College of Obstetricians and Gynecologists; Fellow, American College of Surgeons. Reviewer, *Obstetrics and Gynecology*; *International Journal of Gynecology and Obstetrics*; *The American Journal of Obstetrics and Gynecology*; and *Gynecologic Oncology*.



**Richard L. Keenan, MD**  
Richmond, VA

Professor and Chairman, Department of Anesthesiology, Medical College of Virginia, Richmond. MD, 1957, Creighton University School of Medicine, Omaha. Diplomate, American Board of Anesthesiology. Member, American Society of Anesthesiologists; International Anesthesia Research Society; Society of Neurosurgical Anesthesia and Neurological Supportive Care; Society for Education in Anesthesia; and Society of Ambulatory Anesthesia.



**David Alan Ahlquist, MD**  
Rochester, MN

Consultant in Internal Medicine and Gastroenterology, Mayo Clinic, and Associate Professor of Medicine, Mayo Medical School. MD, 1977, Mayo Medical School. Member, American Gastroenterological Association; American Society for Gastrointestinal Endoscopy; and International Gastrosurgical Club. Reviewer, *Digestive Diseases and Sciences*; *Mayo Clinic Proceedings*; *Gastroenterology*; *New England Journal of Medicine*; *Annals of Internal Medicine*; and *American Journal of Medicine*.



**William B. Applegate, MD**  
Memphis, TN

Professor of Preventive Medicine and Medicine; and Chief, Division of Geriatric Medicine, Departments of Medicine and Preventive Medicine, The University of Tennessee College of Medicine, Memphis. MD, 1972, University of Louisville School of Medicine. Diplomate in Geriatric Medicine, American Board of Internal Medicine. Member, American Geriatrics Society and The Gerontological Society of America. Fellow, American College of Physicians. Section Editor, *Journal of American Geriatrics Society*.



**William J. Riley, MD**  
Gainesville, FL

Associate Professor, Departments of Pathology and Pediatrics, University of Florida College of Medicine; and Medical Director, Clinical Chemistry Section of Shands Hospital Laboratory, Gainesville, MD, 1971, University of Kentucky. Member, College of American Pathologists; Society of Pediatric Research; International Diabetes Immunotherapy Group; and Fellow, American Academy of Pediatrics. Editorial Board, *Diabetes Care*.



**Alan Blum, MD**  
Houston, TX

Assistant Professor, Coordinator of Patient Education and Health Promotion, Department of Family Medicine, Baylor College of Medicine, Houston, MD, 1975, Emory University School of Medicine, Atlanta. Fellow, American Academy of Family Physicians. Founder (1977) and Chairman of DOC (Doctors Ought to Care — a national, non-profit organization of health professionals developing new approaches for health promotion through the mass media). Recipient of The Surgeon General's Medallion in 1988.



**Paul H. Lange, MD**  
Seattle, WA

Professor and Chairman of Urology, University of Washington, Seattle, MD, 1967, Washington University Medical School, St. Louis. Member, American Society of Clinical Oncology; American Urological Association; and Endourological Society. Editorial Board, *Journal of Urology*; *World Journal Update Series*; *World Journal of Urology*; *Journal of Endourology*; *Western Journal of Medicine*; and *Contemporary Urology*.



**Bruce W. Pearson, MD**  
Jacksonville, FL

Serene M. and Frances C. Durling Professor of Otorhinolaryngology, Mayo Medical School, and Head of Section of Otolaryngology, Mayo Clinic Jacksonville, MD, 1966, University of Toronto Medical School. Member, Society of Head and Neck Surgeons and American Society of Head and Neck Surgery. Fellow, Royal College of Surgeons of Canada; American College of Surgeons; American Academy of Otolaryngology/Head & Neck Surgery; American Academy of Facial Plastic and Reconstructive Surgery; American Laryngologic Society; and American Rhinologic Society. Editor, *Journal of Otolaryngology — Head and Neck Surgery*, 1984-1990.



**Milton Thomas Edgerton, MD**  
Charlottesville, VA

Professor of Plastic Surgery, University of Virginia Medical Center, Charlottesville, MD, 1944, Johns Hopkins University School of Medicine. Member, American Association of Plastic Surgeons (President, 1973-74); American Society of Plastic and Reconstructive Surgery; Plastic Surgery Research Council (Founder); Society of Head and Neck Surgeons (Founder); International Confederation for Plastic and Reconstructive Surgery; International Society for Aesthetic Plastic Surgery; Academic Advisory Council for Plastic Surgery (Founder); American Society of Maxillofacial Surgeons; and International Cranio-maxillofacial Society (Founding Member). Fellow, American College of Surgeons. Member, International Editorial Board of *Excerpta, Plastic Surgery Division*. Listed in *International Who's Who in Medicine*, 1986.

PHOTO NOT  
AVAILABLE

**Stuart J. Salasche, MD**  
Boston, MA

Assistant Professor, Dermatology, Harvard Medical School, Boston, MD, 1967, University of Illinois Medical School. Member, American Academy of Dermatology; American Society of Dermatologic Surgery; American College of Mohs Micrographic and Cutaneous Oncology; International Society for Dermatologic Surgery; and Southern Medical Association.





**Barbara F. Atkinson, MD**  
Philadelphia, PA

Professor and Chairman, Department of Pathology and Laboratory Medicine, Medical College of Pennsylvania, Philadelphia. MD, 1974, Jefferson Medical College, Philadelphia. Member, College of American Pathologists; International Academy of Pathology; American Association of Pathologists; American Society of Clinical Pathologists; American Medical Women's Association; and Association of Pathology (Chairman). Trustee, The American Board of Pathology (first woman to serve on the 12-member board). Editorial Board, *Laboratory Investigation* and *Modern Pathology*.



**Dan M. Spengler, MD**  
Nashville, TN

Professor and Chairman, Department of Orthopaedics and Rehabilitation, Vanderbilt University, Nashville. MD, 1966, University of Michigan Medical School, Ann Arbor. Member, American Board of Orthopaedic Surgery (Director); International Research Society for Orthopaedics and Traumatology; and American Orthopaedic Association. Fellow, American College of Surgeons and American Academy of Orthopaedic Surgeons. Editor, *Journal of Spinal Disorders*.



**Sanford I. Finkel, MD**  
Chicago, IL

Director, Geropsychiatric Services, Northwestern Memorial Hospital, Chicago. MD, 1967, University of Michigan Medical School, Ann Arbor. Member, American Association for Geriatric Psychiatry (Founder) and International Psychogeriatric Association. Fellow, American Psychiatric Association. Editorial Board, *Clinical Gerontologist* and *Journal of Geriatrics and Gerontology in Education*.



**Thomas Fugate Smith, MD**  
Atlanta, GA

Director, Division of Allergy/Immunology, Department of Pediatrics, and Associate Professor of Pediatrics, Emory University School of Medicine, Atlanta. MD, 1974, University of Virginia, Charlottesville. Fellow, American Academy of Pediatrics; American Academy of Allergy and Immunology; American College of Allergy and Immunology; American In Vitro Allergy/Immunology Society; and American College of Chest Physicians. Member, American Thoracic Society and American Association of Immunologists. Editorial Board, *Annals of Allergy*.



**Neal Little, MD**  
Ann Arbor, MI

Clinical Instructor in Internal Medicine, Department of Surgery, University of Michigan Medical School; Emergency Physician, St. Joseph Mercy Hospital, Ann Arbor. MD, 1974, University of Michigan Medical School. Fellow, American College of Emergency Physicians.



**N. A. Mark Estes, III, MD**  
Boston, MA

Director, Cardiac Electrophysiology Laboratory and Professor of Medicine, Tufts University, Boston. MD, 1977, University of Cincinnati. Member, American College of Physicians and Fellow, American College of Cardiology. Diplomate, American Board of Internal Medicine. Reviewer, *New England Journal of Medicine*; *American Journal of Cardiology*; *Journal of the American College of Cardiology*; *Clinical Cardiology Alert*; *American Heart Journal*; *Clinical Cardiology*; and *Choices in Cardiology*.



**Jeffrey S. Harris, MD**  
Nashville, TN

Medical Director, Partners Health Plan of Tennessee; President, Harris Associates, P.C. MD, 1975, The University of New Mexico; MBA (General Management), 1988, Vanderbilt University. Member, American College of Emergency Physicians. Fellow, American College of Occupational Medicine; American College of Utilization Review Physicians; American Academy of Family Practice; and American College of Preventive Medicine. Editorial Board, *American Journal of Health Promotion*; *Occupational and Environmental Medicine Report*; *Journal of Healthcare Quality Improvement*; and *Healthy Companies*.



**George W. Weinstein, MD**  
Morgantown, WV

Professor and Chair, Department of Ophthalmology, West Virginia University School of Medicine, Morgantown, MD, 1959, New York City at SUNY-Downstate. Awarded a Fogarty International Fellowship from the National Institutes of Health in 1987 and was visiting professor at the University of London's Institute of Ophthalmology. President, American Academy of Ophthalmology and West Virginia Academy of Ophthalmology. Member, Board of Regents, American College of Surgeons. Editor-in-Chief, *Ophthalmic Surgery*.

 **Make plans now to attend:**

## **KMA's 141st Annual Meeting**

**September 30-October 3, 1991**

**Hyatt Regency Lexington/Lexington Center**

**\$74.00 - Single**

**\$84.00 - Double**

**For room reservations**

 **Call - (606) 253-1234**

*(Please identify yourself as being a KMA Meeting attendee)*



## General Sessions Learning Objectives

### **Pap Smear Screening — The Bethesda Reporting System**

Robert C. Park, MD

To know the recommended guidelines for Pap smear screening; be familiar with the Bethesda terminology system; understand the rationale for classifying squamous intraepithelial lesions (SIL) as high or low grade only; and know the appropriate management of patients with abnormal Pap smears.

### **Recent Advances in the Use of PSA in Prostate Cancer**

Paul H. Lange, MD

Prostatic Specific Antigen (or PSA) is a protein unique to prostatic tissue both malignant and benign. The detection of this substance in the serum has revolutionized the diagnosis and management of prostate cancer making it one of the better serum tumor markers in medical oncology. As with all markers, this specific knowledge of their application is necessary. This lecture will review the established uses of PSA in the diagnosis staging of prostate cancer in addition to their value after treatments such as radiotherapy, radical prostatectomy, and endocrine therapy. Data suggesting newer applications will also be discussed.

### **Cancer Prevention Strategies**

Walter Lawrence, Jr, MD

To develop an appreciation of those human cancers for which cancer prevention strategies may be feasible now or in the future; to become aware of cancer prevention approaches that are already proven to be effective for implementation; and to become alert to potential cancer prevention strategies that still require clinical trials to establish their proper role.

### **The Road to the Prevention of Type I Diabetes**

William J. Riley, MD

To understand the natural history of the "prediabetic" phase of Insulin Dependent Diabetes (IDD); to describe the genetic risk factors for the development of IDD; to describe the usefulness of the current screening tests for the "prediabetic" state; and to understand the potential therapies for the prevention of IDD.

### **Preventing Suicide in Your Elderly Patients**

Sanford I. Finkel, MD

To help the primary care physician, as well as other physicians, focus immediately on the significant risk factors for suicide to help them be aware of the role of the physician in facilitating or preventing suicide.

### **Screening/Quality Assurance in Cytology**

Barbara F. Atkinson, MD

To review the quality assurance issues related to prevention of cervical cancer; be familiar with the Bethesda System in order to address issues of communication of diagnosis between the cytopathologist and the requesting physician; be familiar with guidelines to standardize the method of obtaining a Pap smear and fixing it so that optimal diagnostic material will be present on the slide; and be familiar with the Federal Government's attempts to address issues of quality control assurance and proficiency in the operation of the cytology laboratory.

### **The Physician's Role in Ending the Tobacco Pandemic**

Alan Blum, MD

To list five obstacles to successful health promotion; name cancers — seven warning signals according to Doctor Blum; and list five strategies for ending the tobacco pandemic.

### **Prevention of Malpractice in the Emergency Room Setting**

Neal Little, MD

The participant will be aware of the highest risk areas of malpractice in the emergency room setting; specific strategies to lessen the risk for those factors given above; and components of the interaction between the emergency physician and other attending physicians that lead to high risk in the emergency department setting.

### **The Psychodynamics of Plastic Surgery**

Milton T. Edgerton, MD

To introduce the practitioner to psychological data obtained in an ongoing study of patients seeking plastic surgery between 1950 and 1990. The impacts of a sense of deformity on human function and happiness are documented. The role of surgery in changing such patients is evaluated and the methods of prevention of late and progressive unfavorable personality changes are described. Methods of recognition of candidates who have mental health problems that may be expected to respond to plastic surgery are described. The appropriate use of a health care team comprised of a plastic surgeon and a behavioral medicine scientist is suggested as a cost-effective form of health care.

**Prevention and Quality Improvement Opportunities in Occupational Medicine**

Jeffrey S. Harris, MD

The participants will be able to identify three opportunities for occupational injury prevention; identify opportunities and methods for injury and disability management; and identify opportunities and methods for medical care quality improvement.

**The Importance of Altering Cardiovascular Risk Factors in Elderly Persons**

William B. Applegate, MD

To understand and be able to describe the most important cardiovascular risk factors for older persons and their relative importance and describe whether ample data exist to recommend intervention on these risk factors.

**New Strategies in the Preventive Care for Asthma**

Thomas F. Smith, MD

The participant will be able to increase physicians' awareness of the mechanisms of airway inflammation in asthma and the pharmacotherapy of this inflammation, and to provide physicians with guidelines for establishing and maintaining control of their patient's asthma.

**Preventing Vision Loss: Diabetes 2000**

George W. Weinstein, MD

The presentation will be to emphasize the retinal vascular signs which can lead to visual loss in a diabetic patient.

**The Prevention of Anesthetic Mishaps**

Richard L. Keenan, MD

To review the cost, in malpractice dollars, of anesthesia-related death and severe disability; explores the major causes of past anesthetic mishaps; describes possible preventive measures; and reviews the changes to date in the incidence and cost of mishaps brought about by the use of preventive measures.

**Laryngeal Cancer: How Current Treatment Strategies Can Eliminate The Loss of Speech**

Bruce W. Pearson, MD

To understand how newer diagnostic modalities allow earlier recognition of laryngeal and pharyngeal cancer; to understand how current reconstructive surgical techniques preserve or restore voice after laryngeal or pharyngeal cancers are excised; and to understand how patients can speak after surgery for head and neck cancer.

**Skin Cancer Prevention and Treatment**

Stuart J. Salasche, MD

Participant should have an understanding of the relationship between ultraviolet radiation and the development of certain skin cancers as well as accelerated aging of the skin. Presentation will also include identification of the high risk patient, methods of limiting UV exposure (sunscreens, clothing) and the role of chemopreventive agents such as the retinoids.

**Low Back Pain: A New Look at an Old Problem!**

Barth A. Green, MD

To understand the pathophysiology and biomechanical characteristics of low back pain syndrome; to perform an adequate history, physical and neurological examination on low back pain patients; to order and understand the various imaging modalities available for low back pain evaluations; to understand and implement aggressive conservative approach to low back pain management including educational and physical therapy programs; to understand the basic surgical approaches and alternatives to surgery for low back pain syndromes; to be familiar with specific problem patients including the failed back patient, the workmen's compensation patient and the patient involved in active litigation with low back pain; and be familiar with programs for prevention and management of low back pain syndrome in the future.

**Low Back Pain: Newer Insights into a Longstanding Problem**

Dan M. Spengler, MD

To develop an insight into the complexities encompassed by the low back pain problem. The role of physicians, attorneys, claimants, employers, and third parties in fueling this problem will be reviewed. Preventive measures will be discussed as will appropriate assessment and treatment strategies to optimize recovery and cost containment.



## **Occult Blood: A Flawed Screening Marker for Colorectal Cancer**

David A. Ahlquist, MD

To understand the assumptions upon which current approaches to colorectal cancer screening are based. To appreciate the technical limitations of fecal blood testing. To gain knowledge of occult bleeding patterns with asymptomatic colorectal neoplasms. To review new data on the sensitivity, specificity, and predictive value of fecal blood testing for colorectal cancer. To glimpse present and future alternative strategies to screening.

## **Evaluation and Management of Ventricular Arrhythmias: A Post C.A.S.T. Analysis**

N. A. Mark Estes, III, MD

To know and understand the results of the C.A.S.T. Trial and implications for treatment of post myocardial infarction patients with antiarrhythmic drugs; the methods of risk stratification (spontaneous arrhythmia, LV ejection fraction, signal-averaged ECKG) of patients with ventricular arrhythmia; the invasive and noninvasive options for assessing the efficacy of pharmacologic therapy for ventricular arrhythmias and the advantages and limitations of each technique; the potential benefits of antiarrhythmic therapy (reduction in symptoms, prevention of sudden cardiac death); the potential risks of antiarrhythmic therapy (CHF, proarrhythmia, noncardiac adverse effects); and the nonpharmacologic options (surgery, implantable devices, ablative techniques) for treatment of ventricular arrhythmias.

# Medical Office and Clinic Staff Claims Prevention Program

**K**entucky Medical Insurance Company will offer a special claims prevention seminar for *medical office and clinic staff* during the KMA Annual Meeting.

Entitled "Risk Prevention Skills for Medical Office and Clinic Staff," the Seminar will be held from 9:00 to 11:00 AM on Thursday, October 3, 1991, in the Regency Ballroom of the Hyatt Regency Hotel, Lexington.

In order to register for this program, please call Kentucky Medical Insurance Company either toll free at (800) 292-1858, or, in the Louisville area, (502) 459-3400.

Each participant will be mailed a self-study workbook with accompanying answer sheet which should be completed before the seminar on October 3. The answer sheets will be collected at the seminar, scanned by computer, and an individual score report will be sent to each participant.

The cost, which includes the workbook, scoring service, and seminar, is \$25 per office/clinic staff member employed by physicians insured with Kentucky Medical Insurance Company. For office/clinic staff whose physician employer is not insured by Kentucky Medical, the cost is \$35 per person.

Prompt registration is encouraged.

KMIC-Sponsored Breakfast

7:15 - 8:30 am

Wednesday, October 2

Patterson Ballroom D

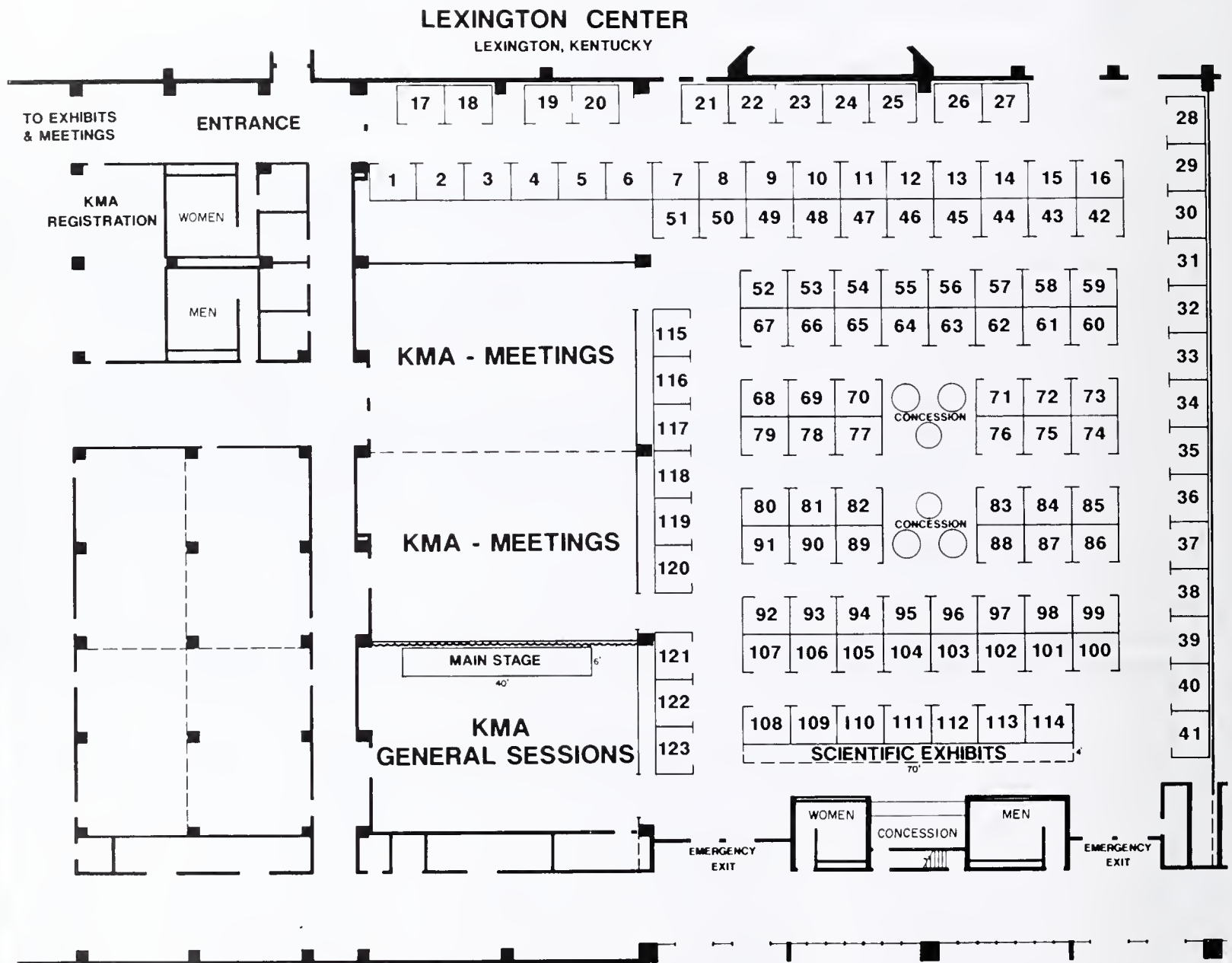
Hyatt Regency Hotel - Lexington

"Everyone Welcome!"





# EXHIBIT HALL FLOOR PLAN

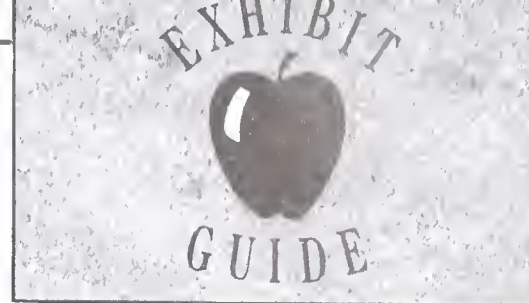


NOTE: ALL EXHIBIT BOOTHS ARE 8'DEEP x 10'WIDE, UNLESS OTHERWISE INDICATED.

**KENTUCKY MEDICAL ASSOCIATION**  
**OCTOBER 1-3, 1991**

All exhibitors with corresponding booth space(s) are listed on this map of the Exhibit Hall. We regret that due to printing and publication deadlines, not all exhibitors are represented in this Exhibit Guide. For more detailed information on the exhibitors, refer to the Technical Exhibits listing beginning on page 420, and please visit them in the Exhibit Hall.

# EXHIBITOR DIRECTORY



Abbott Laboratories #1	HealthNet Aeromedical Services #97	The Medical Protective Company #95 & #96	Searle #11
Alpha-Claim Processing Center #14	Healthware, Inc. #49	Merck Sharp & Dohme #92	Shearson Lehman Brothers, Inc. #88
Berlex Laboratories #17	Hoechst-Roussel Pharmaceuticals, Inc./ The Upjohn Company #34	Metropolitan Reference Laboratories, Inc. #26	Skycare — Jewish Hospital HealthCare Service #15
Blue Cross and Blue Shield of Kentucky #63	Humana, Inc. #66	Miles, Inc., Pharmaceutical Division #108	SmithKline Beecham Clinical Laboratories #70
Boots Pharmaceuticals #9	ICI Pharmaceuticals Group #123	National Health Laboratories, Inc. #118	SmithKline Beecham Pharmaceuticals #114
Bristol Laboratories #52	Image Technology, Inc. #22	Norton Psychiatric Clinic #80	Southeastern Data Systems, Inc. #24
Burroughs Wellcome Company #31	Impath Laboratories #72	Norwich Eaton Pharmaceuticals, Inc. #13	SpectraCare, Inc. #8
Carnrick Laboratories, Inc. #23	Insurance Corp. of America #3	Olympus Corporation #69	Squibb U.S. Pharmaceutical Division #20
Central Pharmaceuticals, Inc. #51	James Graham Brown Cancer Center #4	Ortho Pharmaceutical Corporation #82	Summit Pharmaceuticals #119
Charter Hospital of Paducah #121	Jewish Hospital HealthCare Services #29	Parke-Davis #59	3M Pharmaceuticals #43
Ciba Pharmaceuticals #116	Kentucky Air National Guard #60	Pathology and Cytology Laboratories, Inc. #90	UNICO, INC. #5
Clayton L. Scroggins Associates, Inc. #84	Kentucky Beef Cattle Association #78	Pfizer Laboratories #71	United States Air Force #85
Convatec — A Bristol Myers Squibb Company #94	KY Medical Insurance Co. #30	The PIE Mutual Insurance Co. #107	United States Army Medical Department #28
CVC Mobile Diagnostics #12	KY Telco Federal Credit Union #42	RANAC Computer Corporation #81	University of Kentucky Hospital #21
Disability Determinations #50	Key Pharmaceuticals #106	Ransdell Surgical, Inc. #10	The Upjohn Company #79
Dista Products Company #120	Knoll Pharmaceuticals #83	Rhone-Poulenc Rorer Pharmaceuticals, Inc. #115	Upjohn HealthCare Services #62
Dodson Group #65	Lakeview Rehabilitation Hospital #73	Roerig #89	VonLehman & Company #25
Eli Lilly and Company #16	Lederle Laboratories #77	ROHO Services Division #74	Wallace Laboratories #99
Fisons Pharmaceuticals #6	Lincoln Trail Hospital #87	Ross Laboratories #2	Whitby Pharmaceuticals, Inc. #61
Giegy Pharmaceuticals #117	Marion Merrell Dow, Inc. #18	Saint Joseph Hospital #32 & #33	Whitehall Laboratories #7
Glaxo, Inc. #76	McNeil Consumer Products Company #91	Sandoz Pharmaceuticals #64	Wisner*Martin #36
Good Samaritan Hospital #27	Mead Johnson Nutritionals #68	Savage Laboratories #46	Wyeth-Ayerst Laboratories #75
Greentree Applied Systems, Inc. #93	Mead Johnson Pharmaceuticals #67	Schering Corporation #19	Zila Pharmaceuticals, Inc. #38
Grogan's Healthcare Supply #35			





## TECHNICAL EXHIBITS

The Technical Exhibits at the 1991 KMA Annual Meeting will feature the latest developments in medical techniques and information. Located in the Lexington Center, the exhibits will condense a volume of information and ideas in such a manner that a vast amount of knowledge can be secured in a short period of time.

Prepared carefully and skillfully to appeal to you, the physician, the exhibits are especially geared to your special interests as a practitioner. Medical representatives and other exhibitors will be on hand to discuss personally their products and services with you. Both you and your patients should benefit from the information that can be gained from a visit to the Technical Exhibits.

Thirty-minute intermissions have been planned during each general and specialty group session so that every physician may take advantage of this excellent opportunity provided by exhibits.

**Abbott Laboratories** #1  
**Pharmaceutical Products Division**  
One Abbott Park Road  
Abbott Park, IL 60064-3500  
(708) 937-3281

You are cordially invited to visit the Abbott booth which will feature ProSom™ (estazolam CIV), a new hypnotic to give your patients the sleep of their dreams, Abbott Vision™ (office diagnostic system), Hytrin® (terazosin HCl), Ogen® (estropiate tablets, USP), PCE® 500 (erythromycin particles in tablets) and various Abbott products. Please check at the exhibit to see what's new!

**Alpha-Claim Processing Center** #14  
3504 S Highway 393  
LaGrange, KY 40031  
(502) 244-5559

**Berlex Laboratories** #17  
300 Fairfield Road  
Wayne, NJ 07470  
(201) 305-5082

**Blue Cross and Blue Shield of Kentucky** #63  
9901 Linn Station Road  
Louisville, KY 40223  
(502) 423-2150  
Physician relations will be available during the exhibit with information about Blue Cross and Blue Shield of Kentucky programs.

**Boots Pharmaceuticals** #9  
300 Tri-State International Center,  
Suite 200  
Lincolnshire, IL 60069-4422  
(318) 861-8200

**Bristol Laboratories** #52  
2400 W Lloyd Expressway B413  
Evansville, IN 47721  
(812) 429-5000

We cordially invite you to visit our exhibit to meet our representatives who welcome the opportunity to discuss products and services of interest to you. Featured will be Enfamil, Nutramigen, Poly-Vi-Flor, ProSobee, Ricelyte, and Temptra.

**Burroughs Wellcome Company** #31  
448 Chelsea Woods Dr  
Lexington, KY 40509  
(606) 269-2408

**Carnrick Laboratories, Inc.** #23  
65 Horse Hill Road  
Cedar Knolls, NJ 07927  
(201) 267-2670

Carnrick Laboratories proudly presents our premier line of brand name pharmaceuticals at very economic prices: Theox, Nolex La, Salflex, Skelaxin, Midrin, Nalamine, and Phrenilin. The low-price leader with brand name quality.

**Central Pharmaceuticals, Inc.** #51  
120 E Third St  
Seymour, IN 47274  
(812) 522-3915

**Charter Hospital of Paducah** #121  
PO Box 7609  
Paducah, KY 42002-7609  
(502) 444-0444

Charter Hospital is a psychiatric hospital specializing in comprehensive care for adults and adolescents with emotional and/or substance abuse problems.

**Ciba Pharmaceuticals** #116  
5587 Dove Lane  
West Chester, OH 45069  
(513) 779-9116

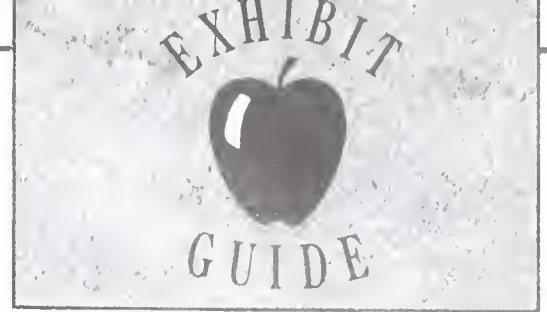
**Clayton L. Scroggins Associates, Inc.** #84  
200 Northland Boulevard  
Cincinnati, OH 45246  
(513) 771-7070

Management consulting and income tax planning for doctors exclusively. Assisting doctors with the business of medical practice. Impartial counsel in a professional, comprehensive and confidential manner on a fee for service basis. Services throughout Kentucky, Ohio and Indiana.

**Convatec — A Bristol Myers Squibb Company** #94  
19 Barrett Dr  
Ft. Thomas, KY 41075  
(606) 441-9337

Convatec is the leader in wound care and ostomy care. We provide innovative products such as DuoDerm® that provides a moist wound environment to enhance wound healing. It is indicated for pressure sores, leg ulcers, skin graft donor sites, and first and second degree burns. Convatec also manufactures Stomahesive® and the SurFit® Ostomy Products to help improve the quality of life for people with ostomies.

**CVC Mobile Diagnostics** #12  
6400 Dutchmans Lane, Suite 335  
Louisville, KY 40205  
(502) 894-8426  
CVC Mobile Diagnostics introduces a new concept in cardiac diagnosis. Our



mobile units bring "state of the art" equipment directly to the hospital, clinic, or office. Patients can easily avoid costly and inconvenient travel to out-of-town hospitals, and still receive the essential "state of the art" cardiac diagnostic services they require.

**Disability Determinations #50**

#1 Athletic Dr  
Frankfort, KY 40601  
(502) 564-8050 ext. 4023

The treating physician is the most significant provider of medical information for the disability claimant. Without the first-hand medical data which deals with the signs, symptoms, and clinical findings, the Social Security Administration is unable to make a valid decision relative to the claimant's allegations. We appreciate your willingness to be a vital part of this process.

**Dista Products Company #120**

Lilly Corporate Center  
Indianapolis, IN 46285  
(317) 276-2554

Dista Products Company cordially invites all attendees to visit our exhibit at which Dista representatives are available to respond to any questions you have concerning Prozac® (fluoxetine hydrochloride, Dista) and Keftab™ (cephalexin hydrochloride monohydrate, Dista).

**Dodson Group #65**

9201 State Line  
Kansas City, MO 64114  
1-800-825-3760

The Dodson Dividend Plan for Workers' Compensation Insurance gives KMA members the opportunity to reduce premium costs each year with an earned return of premium (dividend). These dividends depend on the combined work-related claim cost of all participating KMA members. A dividend has been paid every year since KMA endorsed the Program in 1986; a 15% return of premium was paid in both 1989 and 1990. For complete details, visit us at the Convention.

**Eli Lilly and Company #16**

Lilly Corporate Center  
Indianapolis, IN 46285  
(317) 276-2554

Eli Lilly Company welcomes the opportunity to support your organization through participation in your exhibit program. We cordially invite you to visit our display and discuss any inquiries you may have concerning Axid™ (nizatidine, Lilly) Ceclor® (cefaclor, Lilly), Humulin® (human insulin of recombinant DNA origin, Lilly).

**Fisons Pharmaceuticals #6**

928 Laurel Hill Road  
Knoxville, TN 37923  
(615) 693-2135

Fisons Pharmaceuticals is committed to making available high-quality health care products and services to all who would benefit. We are world leaders in the research and development of allergy/respiratory products and seek to finance the discovery and development of new improved health care products for tomorrow. We see ourselves as full partners with physicians, nurses, pharmacists, patients and others committed to improving health care.

**Geigy Pharmaceuticals #117**

5587 Dove Lane  
West Chester, OH 45069  
(513) 779-9116

**Glaxo, Inc. #76**

8601 Six Forks Road, Suite 610  
Raleigh, NC 27615

**Good Samaritan Hospital #27**

310 S Limestone  
Lexington, KY 40508-3008  
(606) 252-6612

Good Samaritan's exhibit focuses on leading services — laser surgery, orthopedics and neurosciences, diagnostic radiology, obstetrics and gynecology, and the new Extended Care Facility. An array of support services specifically for physicians and their office staffs are highlighted.

**Greentree Applied Systems, Inc. #93**

629 N Broadway  
Lexington, KY 40508  
(606) 254-6388

The Medistar-90 computer system was designed in 1990 to meet the medical office practice needs of the 90s. It was designed and developed in Kentucky especially for Kentucky practices. Electronic claims submission to Medicaid and Medicare, HMO support, fast efficient patient lookup, fast efficient data entry, custom modifications, appointment scheduling, telephone collections and bad debt are but a few of our outstanding features. The system designers and programmers provide comprehensive after-sale training and support.

**Grogan's Healthcare Supply #35**

1016 S Broadway  
Lexington, KY 40504  
(606) 254-6661

Join us in the Grogan's booth for a close look at the latest innovations in exam room furniture and diagnostic equipment from Midmark, Ritter, and Welch Allyn, with exhibits changing daily.

**HealthNet Aeromedical Services #97**

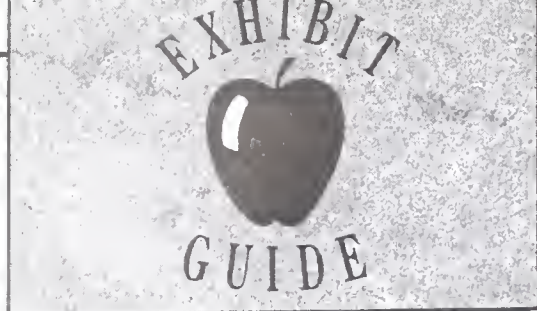
One Saint Joseph Dr  
Lexington, KY 40504  
(606) 278-9811

HealthNet Aeromedical Services is a network of four hospital-based air medical transport programs. Helicopters are located at Saint Joseph Hospital in Lexington, Kentucky; West Virginia University Hospital in Morgantown, West Virginia; Charleston Area Medical Center in Charleston, West Virginia; and Cabell Huntington Hospital in Huntington, West Virginia. HealthNet programs provide advanced life support helicopter transport to critically ill and injured patients requiring inter-facility transfer to tertiary care, or transport from the scene of an accident.

**Healthware, Inc. #49**

1515 Ring Road, Suite 1  
Elizabethtown, KY 42701  
(502) 769-1122





Healthware, Inc. specializes in automating physicians' offices in all areas of office management, including but not limited to accounts receivable, electronic claims, electronic remittance, accounts payable, appointment scheduling and medical information networks. Healthware, Inc. is a registered dealer for *The Medical Manager*, the most widely-sold medical office management program in the country. Our unique policies, which will save your facility tens of thousands of dollars, includes free installation, unlimited free on-site training, and lifetime free software support to our 800 support line 24-hours a day.

**Hoechst-Roussel Pharmaceuticals, Inc./  
The Upjohn Company #34**

PO Box 2500, Routes 202-206  
Somerville, NJ 08876-1258  
(908) 231-2727

Please stop by the Hoechst-Roussel booth where our professional sales representatives will be prepared to talk with you concerning our recently approved product — ALTACE<sup>™</sup> (ramipril), a new, long acting ACE — Inhibitor indicated for the treatment of hypertension. Altace is being promoted as "an Unforgettable Approach to Antihypertensive Therapy" in terms of ACE — Inhibitor efficiency, patient acceptability, compliance, and dosage administration convenience. The product is jointly marketed by Hoechst-Roussel Pharmaceuticals Inc. and The Upjohn Company. Trental (pentoxifylline) is the only proven effective agent for the treatment of intermittent claudication symptomatic of peripheral arterial disease (PAD). Trental has been shown to improve red cell flexibility and lower blood viscosity. From the innovators in diabetes mellitus research and the originators of sulfonylurea therapy — DiaBeta<sup>®</sup> (glyburide) has been used worldwide in over 95 countries for 14 years. Claforan<sup>®</sup> (cefotaxime sodium) Sterile will also be featured at the Hoechst-Roussel Pharmaceuticals, Inc. display.

**Humana, Inc. #66**

Humana Building, 500 W Main  
Louisville, KY 40202  
(502) 580-3571

Humana is an integrated health care services company that owns and operates 86 hospitals, including seven in Kentucky (four in Louisville and one each in Somerset, Louisa, and Lexington). Physicians are needed in various specialties to join members of our medical staffs in these communities. Stop by our booth to discuss these opportunities.

**ICI Pharmaceuticals Group #123**

Wilmington, DE 19897  
1-800-441-7758

**Image Technology, Inc. #22**

PO Box 21844  
Lexington, KY 40522  
(606) 263-7777

PARADIGM Medical Management Software, offered by Image Technology, Inc., is a comprehensive data processing solution for medical billing, accounting, patient tracking, and practice management. PARADIGM uses the latest data base technology to provide the user with the speed and power required by today's large data bases. At the same time, PARADIGM is very easy to learn and use. Since PARADIGM was developed on an AT&T 3B2-500 computer with the UNIX operating system, it runs on all AT&T platforms from the AT&T 6386 WGS products through the AT&T 3B2-1000 mini computer. This probability provides the end user with investment protection for his software and peripherals, while providing nearly unlimited growth potential.

**Impath Laboratories #72**

1010 Third Ave, Suite 203  
New York, NY 10021  
(212) 935-5858

Impath Laboratories, your partner in pathology, performs the highest quality immunohistochemical staining in-situ hybridization (i.e., HPV subtyping) and DNA Analysis. Impath offers rapid turnaround, unmatched ability in paraffin and return stained slides and histo-

grams. Impath is a CAP accredited laboratory whose expert pathologists are always available to personally answer questions. Services include immunohistochemical tests unlocking diagnostic dilemmas (such as undifferentiated tumors) and prognostic tests such as DNA Analysis, and ER/PR in paraffin, and comprehensive breast cancer panels.

**Insurance Corporation of America #3**

4295 San Felipe, Suite 300  
Houston, TX 77027  
(713) 871-8100

Insurance Corporation of America is a Houston-based professional liability insurance carrier providing coverage for physicians and surgeons nationwide. Policies are sold through Independent Agents.

**James Graham Brown Cancer Center #4**

529 S Jackson St  
Louisville, KY 40202  
(502) 588-6318

**Jewish Hospital HealthCare Services #29**

217 E Chestnut St  
Louisville, KY 40202  
(502) 587-4914

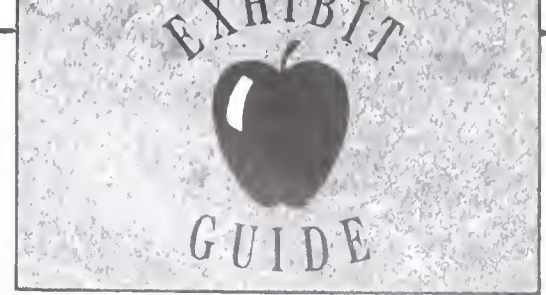
The Physician/Hospital Development Department of Jewish Hospital provides a comprehensive program of physician services with an emphasis on supporting physicians in the private practice of medicine. A professional staff with expertise in practice management, marketing and recruiting works with physicians, developing efficient and profitable private practices. Some of the services provided to physicians include: associate recruitment, office management, consultation, and practice marketing services. Staff members will be available to describe these programs.

**Kentucky Air National Guard #60**

Standiford Field  
Louisville, KY 40213-2678  
(502) 364-9424

The Kentucky Air Guard is a reserve





component of the Air Force. It offers physicians and other medical professionals the opportunity to serve their state and nation in a unique way. Many doctors train to be flight surgeons which gives the opportunity no other part-time career can. You also receive good pay, benefits, retirement, and other valuable training that will enhance your career now.

**Kentucky Beef Cattle Association #78**  
733 Red Mile Road  
Lexington, KY 40504  
(606) 233-3722

Kentucky Beef Cattle Association invites you to visit our exhibit and meet our representatives. We provide a wide variety of nutrition and health information materials for use by professionals. You will be able to see the HeartCare video patient education program for use with patients who need to control fat and cholesterol in their diets. Many patient and professional educational materials will be available.

**Kentucky Medical Insurance Company #30**  
3532 Ephraim McDowell Dr  
Louisville, KY 40205  
(502) 459-3400

Kentucky Medical Insurance Company, organized by the Kentucky Medical Association, is a professional liability insurance company owned by physicians, run by professionals, with physician input in all areas in which there is need of physician expertise. We welcome the opportunity to discuss the advantages and benefits represented by our program of coverage.

**Kentucky Telco Federal Credit Union #42**  
3740 Bardstown Road  
Louisville, KY 40218  
(502) 459-3000 or 1-800-292-9490 (inside Kentucky)

The KMA Credit Union. Offer your staff a fringe benefit that won't cost you a cent! Kentucky Telco is a Federal Credit Union with service centers located in Louisville, Lexington, and Owensboro, all delivering full financial services with

federally insured savings, low cost loans, interest bearing checking, credit cards, Quest ATM, 24-hour telephone service, and discount brokerage. Kentucky Telco is proud to be the only financial institution endorsed by the Kentucky Medical Association.

**Key Pharmaceuticals #106**  
1011 Spearpoint Dr  
Hendersonville, TN 37075  
(615) 822-6326

Key Pharmaceuticals will be displaying its cardiovascular line of products, including Nitro-Dur, K-Dur, and Norm-Odyne. We will also be displaying our respiratory line of products, including Theo-Dur and Trinalin.

**Knoll Pharmaceuticals #83**  
30 N Jefferson Road  
Whippany, NJ 07981  
(201) 428-4037

Knoll Pharmaceuticals cordially invites you to visit our booth for information on Isoptin® SR (verapamil HCl) 240 mg and Isoptin® SR 180 mg, once daily calcium channel blocker approved for the management of essential hypertension and Vicodin® (hydrocodone bitartrate (5 mg Warning: May be habit forming) and acetaminophen 500 mg) and Vicodin® ES (hydrocodone bitartrate (7.5 mg Warning: May be habit forming) and acetaminophen 750 mg) for moderate to moderately severe pain.

**Lakeview Rehabilitation Hospital #73**  
134 Heartland Dr  
Elizabethtown, KY 42701  
(502) 769-3100

Lakeview Rehabilitation Hospital is a 40-bed general medical rehabilitation hospital in Elizabethtown, Kentucky. We have specialized therapeutic programs for stroke, head injury, coma, pulmonary diseases, chronic pain management, neurological disorders, and orthopedic injuries. We serve disabled and injured people of all ages with inpatient and outpatient services such as: Neuropsychology, Occupational Therapy, Physical Therapy, Rehabilitation Nurs-

ing, Respiratory Therapy, Speech Pathology, Work Hardening.

**Lederle Laboratories #77**  
One Cyanamid Plaza  
Wayne, NJ 07470  
(201) 831-4422

You are cordially invited to visit the Lederle booth where we would like to discuss VERELAN® and SUPRAX® with you. VERELAN® (verapamil HCl) pellet filled capsules are once-a-day calcium channel blockers for hypertension. SUPRAX® cefixime is a third-generation oral cephalosporin antibiotic. It is useful in the treatment of otitis media, acute bronchitis, acute exacerbation of chronic bronchitis, urinary tract infections and pharyngitis.

**Lincoln Trail Hospital #87**  
3909 S Wilson Road  
Radcliff, KY 40160  
(502) 351-9444

Lincoln Trail Hospital is an acute psychiatric and chemical dependency, 67 bed facility located in Radcliff, KY, 25 miles south of Louisville. Three patient populations are served; adolescent, adult chemical dependency, and adult psychiatric.

**Marion Merrell Dow, Inc. #18**  
9300 Ward Parkway  
Kansas City, MO 64114  
(816) 966-4000

**McNeil Consumer Products Company #91**  
1411 Opus Place, Suite 656  
Downers Grove, IL 60515  
(708) 969-2772

McNeil Consumer Products Company invites you to visit our exhibit, featuring TYLENOL® acetaminophen products, and other fine McNeil products. Extra-Strength TYLENOL® Gels and Caplets will be highlighted, together with Children's TYLENOL® line of products. We're pleased to offer fruit-flavored and grape-flavored chewables, cherry and grape elixir, Infant Drops, and Junior-Strength Caplets. We will provide literature introducing the No. 1 Rx liquid





# EXHIBIT GUIDE

ibuprofen products, PEDIAPROFEN.<sup>™</sup> Samples of the PediCare<sup>®</sup> line of symptom-specific children's cold products will be available. We will offer samples of IMODIUM A-D<sup>®</sup> (loperamide hydrochloride), an anti-diarrheal. Finally, we're proud to offer samples and literature for MYLANTA and MYLICON, two products we've recently acquired. Professional samples, information aids, and patient education materials will be available as a service to the health care profession. We encourage your attendance at our exhibit.

**Mead Johnson Nutritionals #68**  
2400 W Lloyd Expressway B413  
Evansville, IN 47721  
(812) 429-5000

We cordially invite you to visit our exhibit and meet our representatives who welcome the opportunity to discuss products and services of interest to you. Featured will be BuSpar (buspirone HCl), Desyrel (trazodone HCl), and Duricef (cefadroxil).

**Mead Johnson Pharmaceuticals #67**  
2400 W Lloyd Expressway B413  
Evansville, IN 47721  
(812) 429-5000

We cordially invite you to visit our exhibit and meet our representatives who welcome the opportunity to discuss products and services of interest to you. Featured will be Corgard (nadolol tablets), Questran Light (cholestyramine for oral suspension).

**The Medical Protective Company #95 & 96**  
PO Box 15021  
Fort Wayne, IN 46885  
(219) 485-9622

With over ninety years of experience in professional liability insurance, The Medical Protective Company continues to provide unsurpassed protection for physicians and dentists exclusively.

**Merck Sharp & Dohme #92**  
West Point, PA 19486  
(215) 661-5000

**Metropolitan Reference Laboratories, Inc. #26**  
11636 Lackland Rd  
St. Louis, MO 63146  
(314) 991-1311

Metropolitan Reference Laboratory (METRO) is a full service clinical laboratory dedicated to excellence of performance in all disciplines of laboratory medicine. METRO is one of numerous Corning Clinical Laboratories strategically located in major metropolitan areas. Our primary goal is to provide exceptional service to clients in our region. Directed by Board Certified Pathologists and Ph.D. level scientists, the laboratory is equipped with state-of-the-art instrumentation and staffed by experienced Supervisors, Technologists and Cytotechnologists. At METRO our primary focus is on quality, quality in testing, and quality in data handling and reporting. METRO is fully accredited by the Department of Health and Human Services, by Medicare, by CAP and by appropriate State Departments of Health.

**Miles, Inc., #108**  
**Pharmaceutical Division**  
400 Morgan Ln  
West Haven, CT 06516  
(203) 937-2000

Representatives from Miles Inc., Pharmaceutical Division will be available to discuss the POWER of Cipro tablets and Cipro i.v. for your office and hospital practice. Come by and share with us how the POWER of Cipro has revolutionized your options for the treatment of LRTI, UTI, Skin and Skin Structure, and Bone and Joint Infections (caused by susceptible organisms as noted in the available prescribing information).

**National Health Laboratories, Inc. #118**  
4500 Conaem Dr  
Louisville, KY 40213  
(502) 456-4700

National Health Laboratories prides itself in providing laboratory results that are precise, accurate, specific, and most importantly, diagnostically useful. NHL voluntarily holds itself to significantly higher standards than required by any

state or federal agency. Our mission: To deliver information and quality results in a timely fashion, to aid in the diagnosis of disease, and to assist in the prevention of suffering and the avoidance of pain.

**Norton Psychiatric Clinic #80**  
200 E Chestnut St  
Louisville, KY 40202  
(502) 629-8850

The Norton Psychiatric Clinic offers a complete array of inpatient and outpatient psychiatric services for the adolescent, adult, and geriatric population. The program is affiliated with the University of Louisville and has expertise in caring for patients with complex medical and emotional disorders.

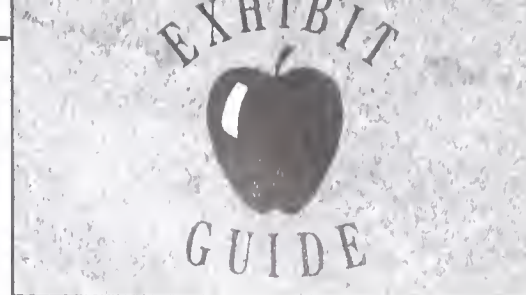
**Norwich Eaton Pharmaceuticals, Inc. #13**  
7 Eaton Ave  
Norwich, NY 13815  
(607) 335-2273

**Olympus Corporation #69**  
4 Nevada Drive Lake  
Lake Success, NY 11042  
(516) 488-3880

**Ortho Pharmaceutical Corporation #82**  
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Raritan, NJ 08869  
(908) 218-6943

Ortho Pharmaceutical Corporation will present the most complete line of medically accepted products for the control of conception. The country's first and most frequently prescribed oral contraceptive, ORTHO-NOVUM 777<sup>™</sup>, will be featured along with other available oral contraceptive dosages and regimens. The newest vaginal antifungal preparation, TERAZOL<sup>™</sup>, will also be featured complimenting a variety of other vaginal therapeutic medications. Numerous patient and professional educational aids will be available for review.

**Parke-Davis #59**  
201 Tabor Road  
Morris Plains, NJ 07950  
(201) 540-3182



We invite you to visit the Parke-Davis booth where our Sales Representatives welcome the opportunity to discuss Lopid®. We hope you will join us.

**Pathology and Cytology Laboratories, Inc.** #90  
290 Big Run Road  
Lexington, KY 40503  
(606) 278-9513  
Private laboratory performing anatomic pathology and cytopathology. Pathologists available to act as Medical Directors or Consultants for hospital laboratories.

**Pfizer Laboratories** #71  
2400 West Central Road  
Hoffman Estates, IL 60196  
(708) 381-9500  
Our exhibit will include the latest information available for our hypertension/angina drug, Procardia XL and our arthritis drug, Feldene.

**The PIE Mutual Insurance Company** #107  
9300 Shelbyville Road, Suite 1001  
Louisville, KY 40222  
(502) 339-7431 or  
1-800-228-7431 (inside Kentucky)  
The PIE Mutual Insurance Company of Cleveland, Ohio now offers Kentucky physicians the advantages of an insurance program that has made it the leading professional liability carrier in Ohio. Owned and controlled by policyholders, the PIE is a non-profit company whose innovative program, unique in the industry, features claims handling by a specialty law firm, physician participation in all areas of operations including peer review of all applicants, and rate stability that rewards loss-free physicians with scheduled premium reductions.

**RANAC Computer Corporation** #81  
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SuperDOS; software modules can be customized to meet requirements of small practices or large clinics; includes electronic transmission of claims, electronic posting of payment, patient information, A/R management, billing, practice analysis, practice marketing, clinical and medical records, appointment scheduler, and word processing. CompreMED™ is available on IBM PS/2 and IBM compatibles.

**Ransdell Surgical, Inc.** #10  
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Louisville, KY 40204  
(502) 584-6311

**Rhone-Poulenc Rorer Pharmaceuticals, Inc.** #115  
500 Virginia Dr  
Fort Washington, PA 19034  
(215) 628-6000  
We are pleased to be a part of this medical meeting and welcome your visiting our exhibit. Representatives will be available to discuss pharmaceuticals manufactured by Rhone-Poulenc Rorer Pharmaceuticals, Inc., including Lozol®, Calcimar®, Nitrolingual® Spray, Slo-bid™, Azmacort®, and DDAVP®.

**Roerig** #89  
235 E 42nd St  
New York, NY 10017  
(212) 573-2323  
Roerig will be featuring two new products. A monoclonal antibody for gram negative shock and a selective serotonin reuptake inhibitor for depression. Representing Roerig will be Hugh Runner, Jim Morgan, Jacques Cobb, Barry Campbell, Stephen White, Carey Rochester, Gary Underwood and Bonnie Kiefer.

**ROHO Services Division** #74  
100 Florida Ave  
Belleville, IL 62221  
(618) 277-9173  
ROHO Services Division will be exhibiting the ROHO Dry Floatation Mattress System, the ROHO Wheelchair cushion, and a new product, the ROHO Dry Floatation O.R. Pad, which provides low

pressure — even distribution to patients who are at the risk of skin breakdown while undergoing lengthy surgical procedures.

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Columbus, OH 43216  
(614) 842-6449  
Ross Laboratories will be showing Suprax — once a day therapy for the treatment of otitis media, bronchitis, pharyngitis/tonsillitis, and urinary tract infections. We will also be showing alimemum protein hydrolysate formula with iron, Similac and Isomil. Makers of a complete line of pediatric nutritional for the growing infant in the first year.

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The largest hospital in central and eastern Kentucky, Saint Joseph Hospital serves as a major referral center for the state. Founded in 1877 as the first hospital in Lexington, Saint Joseph has grown to a 468 bed medical complex, constantly expanding and enhancing services to meet the needs of Kentucky's patients and physicians with a range of specialized and general services.

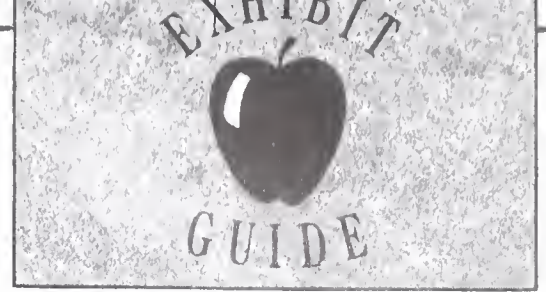
**Sandoz Pharmaceuticals** #64  
59 Route 10  
East Hanover, NJ 07936  
(201) 503-8005

**Savage Laboratories** #46  
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Melville, NY 11747  
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Chromagen, the only liquid iron supplement in a soft gelatin capsule. Mytrex, for the treatment of external candidal infections with inflammation. Trysul, triple sulfa vaginal cream. Epi-pen, auto injector of Epinephrine. Brexin LA, cost effective antihistamine/decongestant. Alphatrex and Betatrex, topical steroids. Doctar, new coal tar shampoo and conditioner.



# EXHIBIT GUIDE

- |  |             |  |             |  |            |
|--|-------------|--|-------------|--|------------|
| <b>Schering Corporation</b><br>2000 Galloping Hill Road<br>Kenilworth, NJ 07033<br>(201) 298-4000  | <b>#19</b>  | <b>SpectraCare, Inc.</b><br>111 E Kentucky St<br>Louisville, KY 40203<br>(502) 584-4040<br>A provider of high-tech home care services, SpectraCare, Inc. provides nursing and pharmacy support for patients requiring IV therapy cardiac care, pediatric care, and general home care. Specialization in staff and equipment meets the needs of patients undergoing state of the art therapy modalities in a home setting.  | <b>#8</b>   | <b>United States Air Force</b><br>2620 Elm Hill Pike, Suite 415<br>Nashville, TN 37214-3159<br>(615) 889-0723  | <b>#85</b> |
| <b>Searle</b><br>5200 Old Orchard Road<br>Skokie, IL 60077<br>(708) 470-6224   | <b>#11</b>  | <b>Squibb U.S. Pharmaceutical Division</b><br>PO Box 4500<br>Princeton, NJ 08543<br>(609) 243-6218<br>Squibb U.S. Pharmaceutical Group has long been a leader in the development of therapeutic and diagnostic products for the prevention, detection, and treatment of diseases. You are cordially invited to meet our representatives who will be available at our exhibit to discuss our full line of health care products, including Capoten and Capozide.   | <b>#20</b>  | <b>United States Army Medical Department</b><br>5111 Leesburg Pike, Suite 638<br>Falls Church, VA 22041-3258<br>(703) 756-8118<br>Physician placement service for the US Army Medical Department, both active duty and reserve. Information will be available about financial assistance as well as the large number of challenging positions in both the Active Army and the US Army Reserve.   | <b>#28</b> |
| <b>Shearson Lehman Brothers, Inc.</b><br>200 S Fifth St, Suite 100 North<br>Louisville, KY 40202<br>(502) 561-4012<br>Through the Consulting Services Division of Shearson Lehman Brothers, I consult to individuals, endowments, and pension plans in hiring a private portfolio manager. This relationship is successful when you can identify a specific manager utilizing an investment style that is closely suited to the client's situation and goals. We follow managers from several assets groups: equity (large cap. to small over the counter), fixed income (taxable and tax-free), balanced and international investments. | <b>#88</b>  | <b>Summit Pharmaceuticals</b><br>5683 Woodbridge Lane<br>West Chester, OH 45069<br>(513) 860-1199  | <b>#119</b> | <b>University of Kentucky Hospital</b><br>Chandler Medical Center<br>800 Rose St<br>Lexington, KY 40536-0084<br>(606) 233-5000<br>UK Hospital is central and eastern Kentucky's only Level I Trauma Center, providing Aeromedical Services and 24-hour trauma care. The 461-bed hospital offers comprehensive services in surgical, cancer, geriatric, cardiac, and burn specialties; pediatrics; obstetrics and gynecology; transplantation; magnetic resonance imaging; and multidisciplinary programs with Markey Cancer Center and Sanders-Brown Center on Aging. UK Hospital is one of only ten in the nation to offer Gamma Knife radiosurgery for previously inoperable brain tumors. | <b>#21</b> |
| <b>Skycare — Jewish Hospital HealthCare Service</b><br>217 E Chestnut St<br>Louisville, KY 40202<br>(502) 587-4230   | <b>#15</b>  | <b>3M Pharmaceuticals</b><br>Building 225-15-07 3M Center<br>St. Paul, MN 55101-9924   | <b>#43</b>  | <b>The Upjohn Company</b><br>3517 Windgate Way, N<br>Lexington, KY 40517<br>(606) 271-9199   | <b>#79</b> |
| <b>SmithKline Beecham Clinical Laboratories</b><br>2277 Charleston Dr<br>Lexington, KY 40577<br>(606) 299-3866<br>Clinical Laboratory.   | <b>#70</b>  | <b>UNICO, INC.</b><br>2709 Washington Ave<br>Evansville, IN 47715<br>(812) 479-3932<br>UNICO, INC. is a dealer for the MEDICAL MANAGER medical office management software program. A complete computer demonstration of the MEDICAL MANAGER program will be available. The MEDICAL MANAGER is distributed nationwide and is currently being used in over 10,000 practices by over 35,000 primary and speciality care physicians. UNICO, INC. can provide a complete office system including hardware, software and all necessary training. | <b>#5</b>   | <b>Upjohn HealthCare Services</b><br>950 Breckinridge Lane<br>Louisville, KY 40207<br>(502) 895-4213<br>Two leaders in home care and staffing services have recently joined forces. Upjohn HealthCare Services is now a wholly-owned subsidiary of the Olsten Corporation. Together we bring more  | <b>#62</b> |
| <b>SmithKline Beecham Pharmaceuticals</b><br>4445 Lake Forest Dr, Suite 520<br>Cincinnati, OH 45242<br>(513) 733-5354  | <b>#114</b> |  |             |  |            |
| <b>Southeastern Data Systems, Inc.</b><br>1016 Weisgarber Road, Suite 110<br>Knoxville, TN 37909<br>(615) 584-1507<br>Complete turnkey hardware and software medical billing, scheduling, medical records, and financial accounting systems.   | <b>#24</b>  |  |             |  |            |



than 40 years experience to serving your home care and staffing needs and have more than 270 offices across North America. Olsten and Upjohn share the same commitment to quality. We were the first international home care company to receive accreditation through JCAHO. (Joint Commissions on Accreditation of Healthcare Organizations.)

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Our Medical Services Group offers services beyond those typically offered by a CPA firm. By specializing in the medical industry, we are better suited to assist medical clients with their unique needs. Each of our clients has a VonLehman senior manager or partner as their advisor. Our management group is supported by over 40 professionals. For 45 years our firm has stood for integrity, initiative and innovation. Our team becomes part of your team.

**Wallace Laboratories #99**  
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We invite you to visit our booth where the Wallace sales representatives will be pleased to furnish information and/or answer any questions on the Wallace ethical products.

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The Lortab Line — a complete line of narcotic analgesics for moderate to moderately severe pain in both liquid and tablet form. Triniscon — the complete hematinic for treatment of today's anemia. Vicon Forte — sensible nutritional therapy. A prescription only multivitamin/mineral product.

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Whitehall Laboratories, a division of American Home Products, manufactures and markets proprietary drugs in the categories of analgesics, cold remedies, and other packaged medicines. Whitehall is a leading organization in its field and is recognized for its high-quality products. Among them there is Advil, Posture, Riopan, and the Today Sponge.

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Wisner\*Martin is a nationally-recognized leader in providing medical computer systems and services. With over 4000 clinicians in 47 states, SM\*RT Practice includes a complete billing ca-

pability, clinical patient information, reports, referral tracking, collection assistance and recalls. Always on the leading edge of technology, Wisner\*Martin offers electronic claims, electronic remittance, appointment scheduling, CD ROM research and custom hospital-physician interfaces. Data conversion, training, installation and ongoing software support and hardware maintenance are provided from corporate headquarters in Spokane, WA and branch offices in Lexington and other national locations.

**Wyeth-Ayerst Laboratories #75**  
Philadelphia, PA 19101

**Zila Pharmaceuticals, Inc. #38**  
5227 North 7th St  
Phoenix, AZ 85014  
(602) 266-6700

Zila Pharmaceuticals manufactures and distributes OTC pharmaceutical products for oral health care. Zila's products are clinically proven and recommended by dentists and pharmacists. Zilactin for canker sores, coldsores/fever blisters; Ziladent for denture sores. Both products contain a unique bioadhesive which allows them to remain on an oral lesion for as long as eight hours, providing protection, relief from pain and a faster healing time. Introducing Zilactol for treating cold sores/fever blisters before they erupt.

## AN INVITATION

**For a chance to visit with your Annual Meeting Exhibitors, join us each morning (Tuesday, Wednesday, & Thursday) in the Lounge area, located in the center of the Lexington Center, from 8:15 am - 9:00 am, for free coffee & danish.**



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All orders for classified advertising must be placed in writing and will be subject to approval by the Editorial Board. The right is reserved to decline or withdraw advertisements at the publisher's discretion.

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**Rates to KMA members:** \$10 per insertion up to 50 words, 25¢ each additional word. To non-members: \$30 per insertion up to 50 words, 25¢ each additional word.

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**KENTUCKY** — If you are retired, semi-retired, or slowing down and would like to work one, two, or three days a week and spend the rest of the time fishing

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**REFURBISHED EQUIPMENT** — Pelton Crane Magnaclave, recording thermometer, warranty, \$6,200.00. Hewlett Packard heart monitors, defibs & printout. Ohio anesthes. machines: Forreger, copper kettle with ethrane & fluothane, vaporizers. Fluothane vaporizers Mark II — \$300.00 each. Ohio vaporizer — isoflurane — \$475.00 each. Coulter counter-CBC-4 with hemoglobin, excellent condition, warranty. Suction pumps, electro surg. units, O.R. lights. One electric and one hydraulic table. Ultrasonic instrument cleaner, warranty. Swift microscope, professionally refurbished. Call or write: Bernard Medical Resources, 1555 Dixie Highway, Covington, KY, 606/581-5205.

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Kentucky Air National Guard  
(502) 364-9424 (call collect)

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The AMA proposal to  
improve access to affordable,  
quality health care.

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That’s why the AMA has launched a proposal to improve access to affordable, quality health care. It’s called *Health Access America*. The message is being sent to Congress, the media, labor and management organizations, concerned groups like AARP, and your fellow physicians.

Simply, *Health Access America* proposes health insurance coverage

for all Americans, regardless of income or health status. It calls for expanded publicly-funded health care for the needy; a stronger Medicare system; employer-provided coverage for all workers and their families with tax incentives for small businesses.

America’s physicians are leading the way to reforming the health care system by speaking out on these critical issues.

To get a copy of the *Health Access America* proposal, please call our Member Service Center at 1-800-AMA-3211.

**The American Medical Association**  
on behalf of member physicians and their patients.





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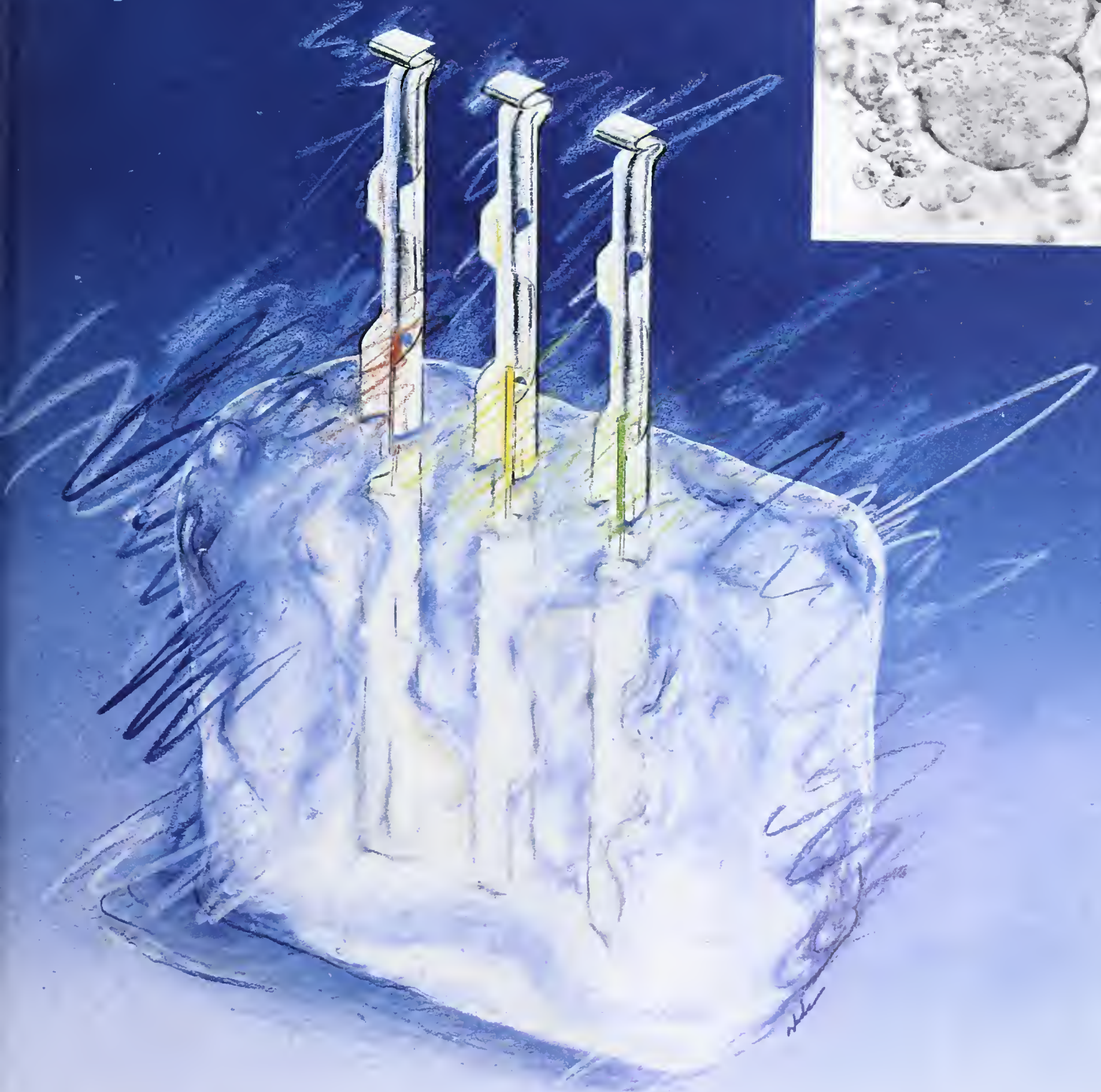
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SEPTEMBER 1991



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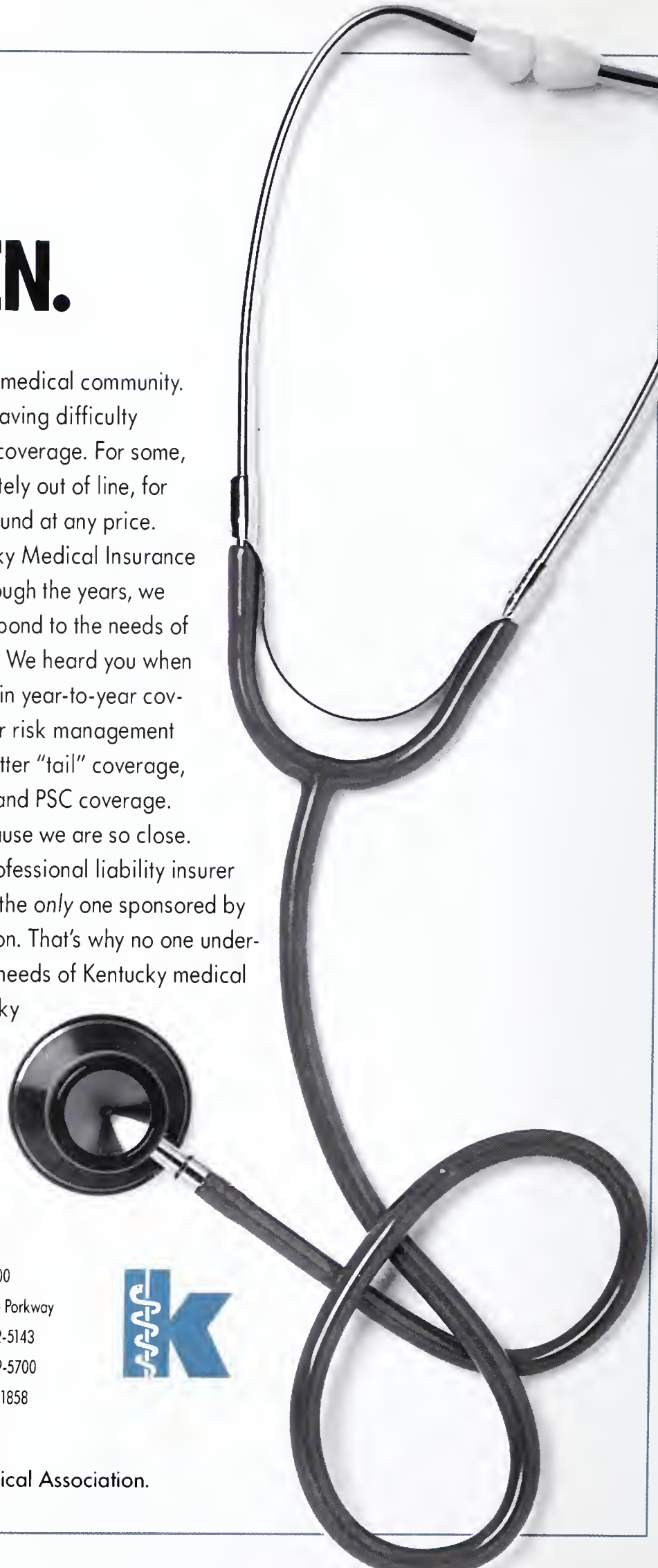
We can hear you so well because we are so close. Kentucky Medical is the *only* professional liability insurer headquartered in Kentucky and the *only* one sponsored by the Kentucky Medical Association. That's why no one understands the professional liability needs of Kentucky medical professionals better than Kentucky Medical Insurance Company. Talk to your Kentucky Medical Insurance Company representative soon. You'll have the ear of a good listener.

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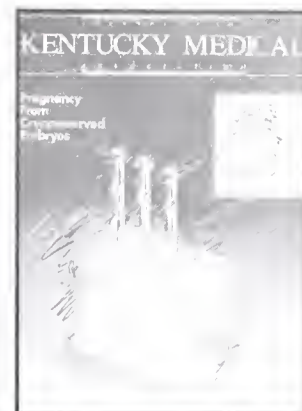


JOURNAL OF THE  
**KENTUCKY MEDICAL**  
ASSOCIATION

VOLUME 89, NUMBER 9

SEPTEMBER 1991

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## Remain True — Pride in Medicine

**T**his has been an extremely exciting and productive year, and I want to thank all members of KMA for the opportunity to serve. It is indeed an honor to represent the physicians of Kentucky in meetings with other physicians and medical groups throughout the United States. Kentucky physicians are fortunate to have an outstanding Board of Trustees who give so freely of their time and effort and meet on a regular basis to make some very difficult decisions, always with the practicing physician at heart. The 1990-91 Associational year has gone by very rapidly. The Special Session of the 1991 Kentucky General Assembly established the Medicaid assessment bill. Your officers, leadership, and staff spent many hours, including Sundays and nights, grappling with this important issue. At the outset, we established the need to place poor patients and physicians who have fairly large Medicaid practices as our major priority. We determined to ignore the rhetoric and the usual criticisms of government-funded programs and attempted to stake out an appropriate and acceptable position. In the end, we made the decision to support HB 21 because it was in the best interests of patients and physicians most affected by this problem.

Testing physicians and health workers for HIV has been an issue throughout the year. Your House of Delegates will probably deal with this issue, which is extremely controversial. In many cases the issue is being politicized to the detriment of not only HIV positive patients and

providers but to the public as well. Medicare funding and federal administration's attempt to misuse RBRVS studies has dominated Medicare's federal agenda. We have written, phoned, and personally visited our Kentucky delegation to Washington expressing our deep concern for the proposed cuts in RBRVS. In addition, we organized a grass roots effort to involve all Kentucky physicians.

I have highlighted only the most controversial issues. We have also had to deal with other problems in the Kentucky General Assembly, federal issues, and general public and media concerns. Despite all our protestations, our future is held in the political balance. Resolution M, which was adopted by the 1990 House of Delegates, urged Kentucky physicians to run for public office and seek policy-setting positions with third-party payors and insurers. This is an important consideration for all of us and we should give it serious thought.

Another issue which the Executive Committee and officers dealt with throughout the year was the sale of the old KMA Headquarters building. The KMA Board of Trustees recommended several years ago that if at all possible the KMA and KMIC staffs should remain in the same building or in a general building complex. KMIC is a rapidly growing corporation and despite the fact that the original building had been added on to twice, it simply was bursting at the seams. KMA staff level has remained constant for many years. While the building was adequate for

***“We need to believe in ourselves and concentrate on what is good about our profession. Above all, we need to remind ourselves of Francis Peabody's 1927 statement which remains just as true today, 'One of the essential qualities of the clinician is interest in humanity. The secret of the care of the patient is in caring for the patient.' So long as we remain true to this principal and always place the patient at the forefront of everything we do, then we remain true to ourselves and maintain "PRIDE IN MEDICINE."”***



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***“Despite all our protestations, our future is held in the political balance. Resolution M, which was adopted by the 1990 House of Delegates, urged Kentucky physicians to run for public office and seek policy-setting positions with third-party payors and insurers. This is an important consideration for all of us and we should give it serious thought.”***

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KMA staff, the building simply has outlived its usefulness for KMIC. Hospice of Louisville purchased the building, and on July 18, 1991, after 31 years, KMA moved its headquarters to North Hurstbourne Parkway in Louisville. There will be a full report to the House of Delegates as to the actions taken. The Board of Trustees and everyone involved was unanimous in their agreement that despite the emotional attachment to the old building, it was time to move on.

In closing, I want to pay special tribute to my home county society, Fayette County Medical Society, for their encouragement and support throughout my medical career. I especially thank my partners for their wonderful cooperation and for filling in and making it possible to serve. Particular gratitude is owed to my family for their sacrifices, especially my wife, Lucille, who has been supportive and stood side by side

with me throughout my career.

While times are difficult, the same problems that medicine faces affect all society, especially budget cuts, government intervention, etc. We started out the year telling you that we intended to focus on the positives of medicine. We need to believe in ourselves and concentrate on what is good about our profession. Above all, we need to remind ourselves of Francis Peabody's 1927 statement which remains just as true today, "One of the essential qualities of the clinician is interest in humanity. The secret of the care of the patient is in caring for the patient." So long as we remain true to this principal and always place the patient at the forefront of everything we do, then we remain true to ourselves and maintain "PRIDE IN MEDICINE."

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# Pregnancy From Cryopreserved Embryos: An Important New Aspect of Assisted Reproduction

Ken Muse, MD; Gina Lentini, RN; Thomas Curry, PhD;  
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*Assisted Reproduction techniques have become well-established methods of treating infertility in the decade since their inception. The gradually improving efficacy of these procedures has made the risks of multiple pregnancy a serious concern. Cryopreservation of "extra" embryos has been developed to counter this problem, but has led to new difficulties. Assisted Reproduction in Kentucky has kept pace with progress worldwide; the first Kentucky live birth from transfer of cryopreserved embryos is reported.*

## Introduction

Successful treatment of infertility by *in vitro* fertilization (IVF) was first reported in 1978,<sup>1</sup> and several variations on the procedure (including GIFT, gamete intrafallopian transfer<sup>2, 3</sup>) have been developed since then. Together, these techniques are termed "Assisted Reproduction." Originally for women with occluded fallopian

tubes, the indications for Assisted Reproduction have broadened until it has become a final common pathway for most patients with infertility not responding to traditional therapies. At present, Assisted Reproduction requires only that the infertile couple have a source for gametes (their own, or from donors), a uterus capable of pregnancy, no contraindication to pregnancy, and an infertility diagnosis not amenable to lesser therapies.

Annual reports from the IVF-ET Registry have documented the overall United States experience with Assisted Reproduction.<sup>4, 5</sup> The 1990 report describes the results of over 22,000 attempts in 135 member clinics in 1988, and reveals an overall clinical pregnancy rate of 16% for IVF, and 27% for GIFT, per oocyte retrieval. Reported pregnancy rates from individual programs vary a great deal, based on the skill and experience of the clinic, the patient population studied, the definition of "pregnancy," and other factors.

Recent years have seen the realization that about 25% to 30% pregnant per cycle seems to be the biologically-set upper limit of human reproductive efficiency; Assisted Reproduction techniques have approached this by maximizing the number of embryos transferred to the uterus. However, it has been appreciated that increasing the number of embryos transferred also increases the incidence of multiple pregnancy among those getting pregnant (Table 1); ironically, multiple pregnancy has become one of the most serious complications of Assisted Reproduction.

Most Assisted Reproduction programs now transfer the three to five embryos with the best morphologic appearance, to give the optimal pregnancy rate that cycle, and then freeze (cry-

**Table 1.** Incidence of pregnancy and multiple pregnancy among pregnant women in assisted reproduction.\*

Number of Embryos Transferred	% Clinically Pregnant	% Multiple Pregnancies
1	8	0
2	19	2.6
3	22	3
4	26	5.5
5	27	8.9
6	20	9.1
7	27	14.3

\*From reference 4.

opreserve) the remaining embryos. The latter are then thawed and transferred to the patient at a later time. This allows one ovarian stimulation and oocyte recovery to provide several embryo transfers. In these developments, Kentucky has kept pace with the nation and the world (Table 2).<sup>6,7</sup> We report here the first live birth in Kentucky from transfer of cryopreserved embryos.

### Case Report

A 38-year-old, married, nulligravid, white female with a 10-year history of infertility was referred to the University of Kentucky Medical Center. Previous evaluation had revealed a regular menstrual pattern, normal hysterosalpingogram, and a husband with a normal semen analysis. Surgical evaluation revealed tubal adhesions and endometriosis; conception had failed to occur after appropriate surgical therapy. They were counseled as to their options, and chose Assisted Reproduction.

In early 1989, the patient began pituitary-ovarian suppression in the luteal phase of her menstrual cycle by GnRH-agonist administration. After 2 weeks, controlled ovarian stimulation was begun, using three ampoules of human menopausal gonadotropins per day for 11 days. Serum estradiol measurements and pelvic ultrasound evaluations were frequently performed. When the estradiol was 1182 pg/mL, and ultrasound revealed multiple follicles 17-19 mm in diameter, an ovulatory dose of human chorionic gonadotropin was given. Two days later, ultrasound-directed vaginal aspiration of the follicles was performed under intravenous sedation. Twelve oocytes were obtained; 1 never fertilized, 1 became polyspermic, and 10 evidenced normal fertilization. Four embryos were transferred to the uterus (two 3-cell embryos and two 2-cell embryos), but pregnancy did not result. (Two other embryos underwent spontaneous degeneration *in vitro*.)

Four embryos were cryopreserved at the pronuclear stage of fertilization. After serial dilutions in the cryoprotectants 1,2-propanediol and sucrose, each embryo was placed in a plastic "straw" and put in a computer-controlled environment (Planer Biomed Kryo 10 Series [Fig 1]) for freezing; they were cooled from 37°C to -8°C at 2°C per minute. The media was then "seeded" with an ice crystal, and the embryos were cooled to -30°C at a rate of 0.3°C/minute. The straws containing the embryos were then placed in liquid nitrogen (-196°C) for storage.

**Table 2.** Milestones ("First births") in assisted reproduction.

	World	USA	Kentucky
IVF	Steptoe, <sup>1</sup> England, 1978	Jones, Norfolk, VA, 1980	University of Kentucky, Lexington, 1986
GIFT	Asch, <sup>2</sup> San Antonio, 1984	(Asch)	University of Kentucky, <sup>3</sup> Lexington, 1987
Cryopreserved Embryos	Mohr, <sup>6</sup> Australia, 1985	Marrs, <sup>7</sup> Los Angeles, 1986	University of Kentucky, Lexington, 1990

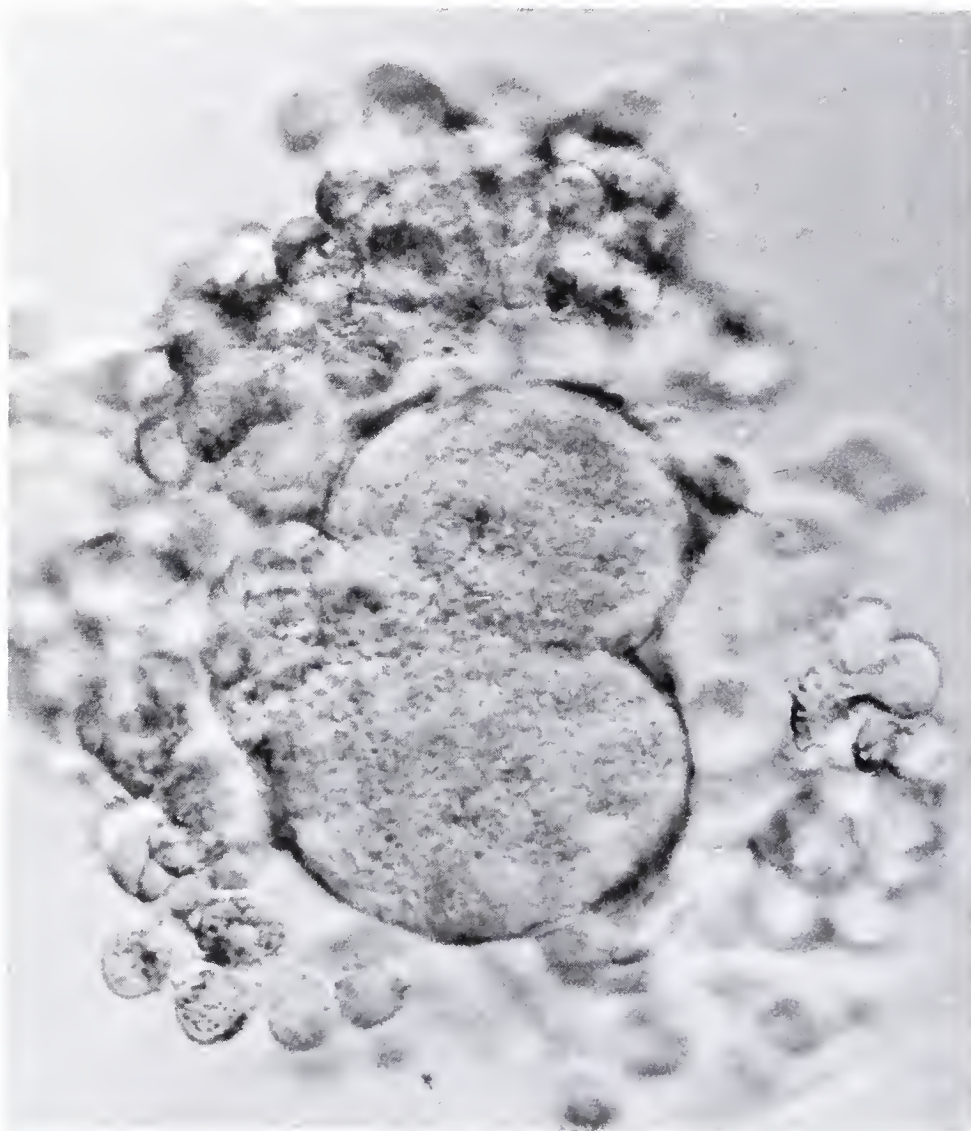


**Fig 1** — Dr Michael Vernon, Chief Embryologist, in the University of Kentucky Embryo Cryopreservation facility. Equipment pictured, clockwise from left: liquid nitrogen storage tank, in vitro embryo incubator, freezing chamber (the disassembled apparatus on the counter holds the embryo freezing straws, and is placed in the chamber during freezing), programmable computer which controls the freezing process, ice crystal seeding mechanism, and liquid nitrogen embryo storage container (in front of Dr Vernon).

Four months later, after a luteinizing hormone surge was observed in a spontaneous cycle, the embryos were thawed by placing them in a 37°C water bath for 30 seconds, then serially diluting them in a succession of media to remove the cryoprotectant. The embryos were then observed for an additional day. Two embryos failed to develop and degenerated *in vitro*. The other two embryos continued fertilization, developing



## Pregnancy From Cryopreserved Embryos



**Fig 2 — Microscopic appearance of the two-cell embryo that resulted in the first live birth from a cryopreserved embryo in Kentucky, taken immediately before transfer to the uterus. The two large cells are the blastomeres of the embryo. The multiple small cells in the periphery are adherent granulosa cells from the ovarian follicle. The indistinct, halo-like area in between is the zona pellucida.**

into a one-cell and a two-cell embryo (Fig 2). These were transferred to the uterus, and administration of progesterone vaginal suppositories (25 mg bid) was started for luteal phase support. Twelve days later a serum pregnancy test was positive, and ultrasound confirmed a viable fetus at 8 weeks gestation. In May of 1990, a healthy female infant was delivered at term, without complications.

#### Development of Cryopreservation

Detailed reviews of embryo and gamete cryopreservation techniques have been made elsewhere.<sup>8,9</sup> In essence, the success of cryopreser-

vation depends on the size of the cells (small cells work best), the state of the chromosomes when frozen, the value placed on individual cells, and adjunctive measures used. Human sperm cells have been successfully cryopreserved for over 40 years. A semen sample can be plunged into liquid nitrogen vapor, rapidly thawed later, and successfully fertilize an oocyte. Sperm cells are very small cells with compact chromatin; they survive freezing "well," but often 50% of cells in a semen sample will not survive. Clinically, this is of little significance due to the millions of cells present in most samples. Oocytes, the largest cells, have dispersed chromatin; no cryopreservation technique has been developed for them which is routinely successful. Fatal damage is done, perhaps due to the formation of ice crystals within the cell during freezing.

Successful embryo cryopreservation has been routinely accomplished by a variety of techniques. They share the use of "cryoprotectants," computer-controlled rate of temperature change, and freezing the embryo at a certain stage of development. Cryoprotectants include DMSO, propylene glycol, sucrose, and glycerol. How the addition of these substances to the media surrounding the embryos helps them to survive freezing is unknown, but stabilizing cell membranes and minimizing ice crystal formation and "osmotic shock" during freezing have been proposed. Different cryoprotectants seem to be preferable for freezing each stage of embryo growth. Although all stages of embryo growth have been successfully cryopreserved, from just after fertilization (a 1-cell, "pronuclear" embryo) to a multicellular blastocyst, a trend towards preferential freezing at the pronuclear stage has emerged.

Reviews of the clinical application of cryopreservation have found that approximately 50% to 60% of embryos survive the freezing process. Pregnancy rates of 10% to 13% per transfer of embryos are seen.<sup>4,5,10</sup> Once pregnant, continued observation reveals outcomes similar to those seen among the general infertile population, or to other forms of Assisted Reproduction (20% miscarriage, 1% to 5% ectopic pregnancy). Children born from both IVF and cryopreserved-embryo pregnancies appear to have no increase in the incidence of birth defects, and normal early development.<sup>11,12</sup>

#### Further Considerations

The success of cryopreservation has caused most

Assisted Reproduction programs to adopt this technique. It is well accepted, and usually desired, by infertile patients. In addition to increasing the chance of pregnancy per stimulation and oocyte recovery, the overall financial cost is decreased (the cryopreservation process is less expensive than repeated, entire Assisted Reproduction cycles). Similarly, medical risks are decreased, and the "emotional risk" following an unsuccessful Assisted Reproduction cycle is somewhat lessened by the knowledge that cryopreserved embryos remain to be transferred at a later date. For women with conditions that normally prevent childbearing (such as premature ovarian failure and Turner's syndrome), some Assisted Reproduction programs have helped them achieve pregnancy using "embryo donation." Cryopreservation has facilitated this by abolishing the requirement for synchronization of donor and recipient menstrual cyclicity.<sup>13, 14</sup>

Alternatives to cryopreservation of "extra" embryos (discarding them, multiple pregnancy, or "selective termination" of multiple pregnancy<sup>15</sup>) are neither practical nor desirable. However, cryopreservation is not without its own problems.<sup>16</sup> Both survival rates and pregnancy rates of frozen-thawed embryos are less than optimal. The technology is expensive and difficult to acquire. Novel medical-legal issues have arisen. The death, disability, or aging of the patient or her husband beyond reproductive years may place the fate of the frozen embryos in question. The couple may divorce or change their minds about childbearing. Mechanical failure may disrupt the long-term storage of embryos, or the Assisted Reproduction program maintaining them may cease operation. For these reasons, most programs require the couple to document their knowledge of, and plans for, these possibilities, and follow guidelines established by national authorities.<sup>17, 18</sup>

Despite these concerns, the proven benefits of cryopreservation have made it a significant advance in reproductive medicine. Physicians caring for infertile couples now have more to offer their patients, and those patients now have an improved chance at achieving their goal — a healthy baby.

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# Splenectomy for Hematologic Disorders: A 20 Year Experience

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From the Departments of Surgery and Medicine, Baptist Hospital East, Louisville, KY. Read before the Kentucky Chapter of the American College of Surgeons Meeting, April 1990, Lexington, KY.

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*A retrospective chart analysis was conducted for all patients undergoing splenectomy for hematologic disorders at the Baptist Hospitals of Louisville between 1970 and 1989. Fifty-nine charts comprise the basis of this review. Variables considered included disease entities treated by splenectomy, indications for splenectomy, and morbidity and mortality associated with the surgery. Additional variables evaluated were splenic weight, estimated blood loss at surgery, technique of splenectomy, and drainage of the splenic bed. The authors found a high correlation of splenic weight to the hematologic disorder treated. Larger spleens were associated with greater blood loss at surgery. Preliminary splenic artery ligation did not reduce the operative blood loss in patients with massive spleens. Drainage of the splenic bed was not associated with postoperative bleeding or intra-abdominal abscess. The low morbidity (22%) and mortality (3.4%) compares favorably to other published studies, demonstrating that splenectomy for hematologic disorders may be safely performed in the community hospital setting.*

## Introduction

Splenectomy for hematologic disorders represents an infrequently practiced procedure in the community hospital setting. The authors undertook this retrospective study to identify the disease entities treated, the safety of splenectomy, and patient factors that contributed to blood loss at surgery, morbidity and mortality.

## Materials and Methods

A chart analysis utilizing the tumor registry and the medical records department of Baptist Hos-

pital Highlands and Baptist Hospital East in Louisville, KY from 1970 through 1989 was performed. Patients who underwent incidental splenectomy or splenectomy following trauma were excluded. Factors evaluated included the disease entities treated, indications for splenectomy, technique of splenectomy, splenic weight, estimated blood loss, and complications following surgery.

All but one of the patients during this 20-year period were cared for by a single group of medical hematologists/oncologists. Eighteen surgeons in private practice in the Louisville community performed the surgical procedures.

## Results

Fifty-nine records were available for analysis. Diagnoses included 17 patients with immune thrombocytopenic purpura, 15 patients with Hodgkin's lymphoma, 10 patients with non-Hodgkin's lymphoma, 7 patients with hairy cell leukemia, and 4 patients with chronic lymphocytic leukemia. An additional 6 patients were placed in a miscellaneous group of benign disorders (Fig 1).

Indications for splenectomy reflected the diseases treated. All of the patients with immune thrombocytopenic purpura underwent splenectomy to manage thrombocytopenia after receiving a trial of systemic steroids. Several of the patients received other medical interventions, including oral danazol, intravenous immune gamma globulin, and chemotherapy. Similarly, all of the patients with Hodgkin's lymphoma underwent splenectomy as part of staging laparotomy. The histologic staging showed 44% with stage IIA, 22% with stage IA disease, 22% with stage IIIS, and 11% with stage IIIB disease.

For those with non-Hodgkin's lymphoma, splenomegaly was the indication for surgery in

50% of patients. Twenty percent were thought to have splenic infarction, 10% had mass lesions in the spleen, 10% were felt to have relapse, and 10% had pancytopenia. The histology of these patients with non-Hodgkin's lymphoma demonstrated the evolution of the classification system over the past two decades. Two patients had nodular poorly differentiated lymphoma (PDL), two patients had nodular lymphoma, one patient had large cell lymphoma, two patients had "non-Hodgkin's lymphoma," one patient had immunoblastic lymphoma, one patient had lymphocytic lymphoma and one patient had diffuse mixed lymphoma.

All patients with hairy cell leukemia underwent splenectomy as their primary therapy. Eighty-six percent were noted to have splenomegaly, 43% had thrombocytopenia, 14% had hypersplenism, and 14% had anemia.

Four patients underwent splenectomy to manage complications of chronic lymphocytic leukemia. Massive splenomegaly was present in 75%, 50% had thrombocytopenia, 50% had anemia, and 25% had pancytopenia.

Six patients in the analysis were placed in a miscellaneous group. Indications for splenectomy in these patients included pericardiotomy syndrome with splenic infarction, splenic abscess following therapy for acute myelogenous leukemia, systemic lupus erythematosus with hypersplenism, congenital spherocytosis, and Laennec's cirrhosis with hypersplenism and myelofibrosis.

The mean splenic weight and mean blood loss during surgery for each of the six groups of patients was calculated (Fig 2). Splenic weights highly correlated with the disease entities being treated. Sixteen patients out of the 59 were considered to have massive splenomegaly, defined as spleens weighing greater than 1000 grams. The mean splenic weight for these 16 patients was 2098 grams, with an estimated mean blood loss of 941 ccs (Fig 3). In the remaining 36 patients with spleens weighing less than 1000 grams (so-called small spleens), the mean weight was 343 grams and the mean estimated blood loss was 415 ccs (Fig 3).

Ten of the 16 patients with massive splenomegaly underwent preliminary ligation of the splenic artery through the lesser omental sac along the superior border of the pancreas prior to removal of the spleen. The estimated blood loss in patients with preliminary ligation of the splenic artery was 975 ccs with a mean splenic weight of

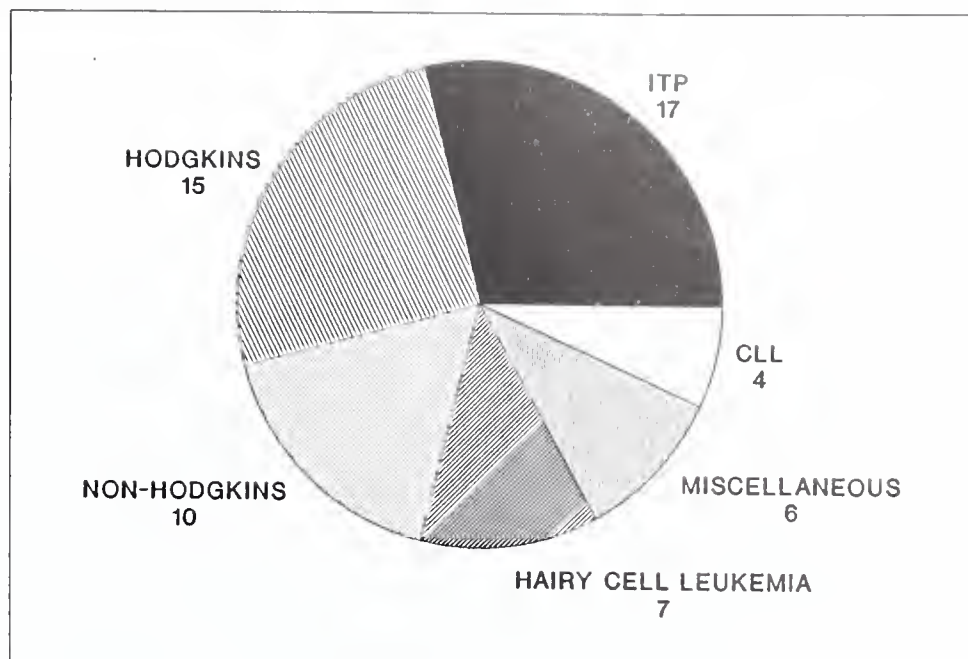


Fig 1 — Hematologic Disorders Managed With Splenectomy.

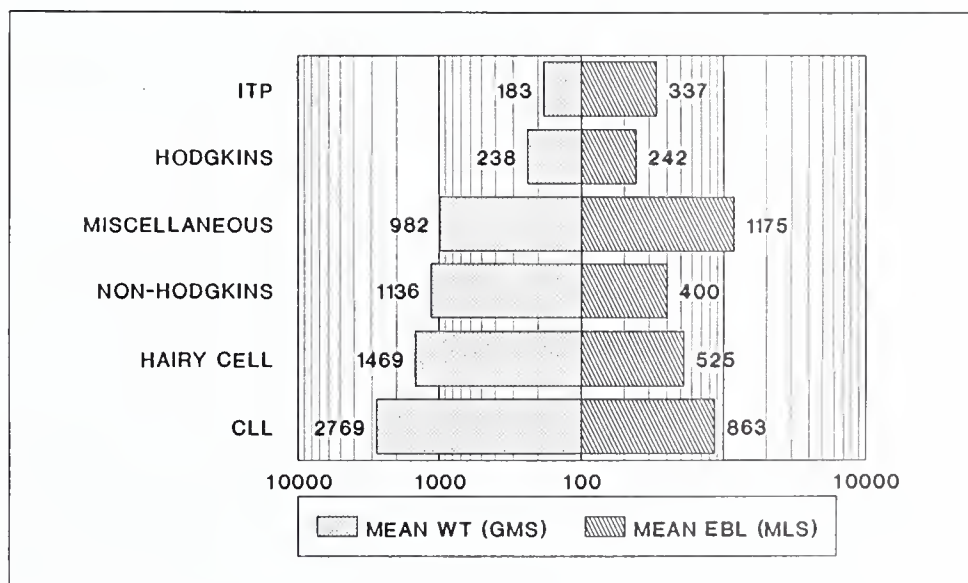


Fig 2 — Splenic Weight and Estimated Blood Loss During Surgery

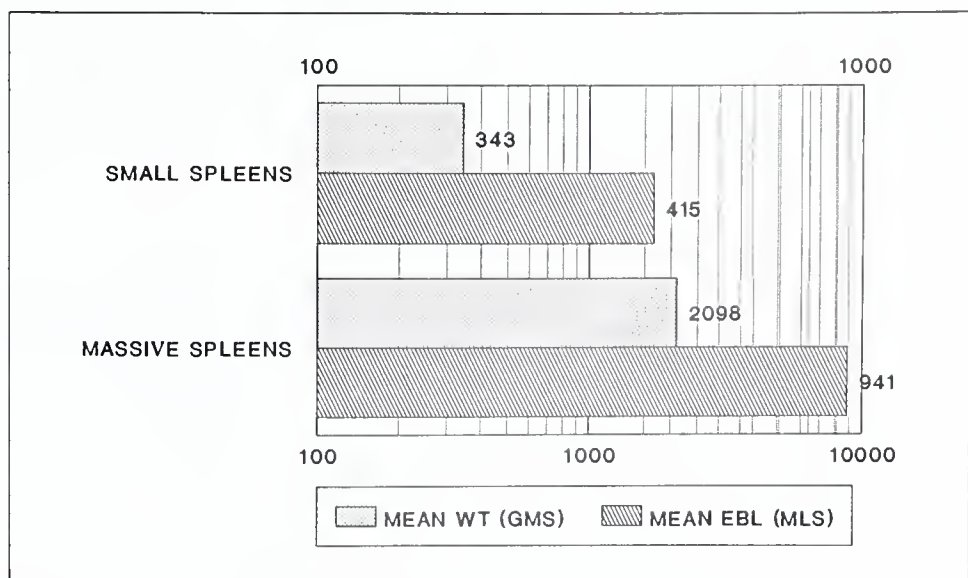
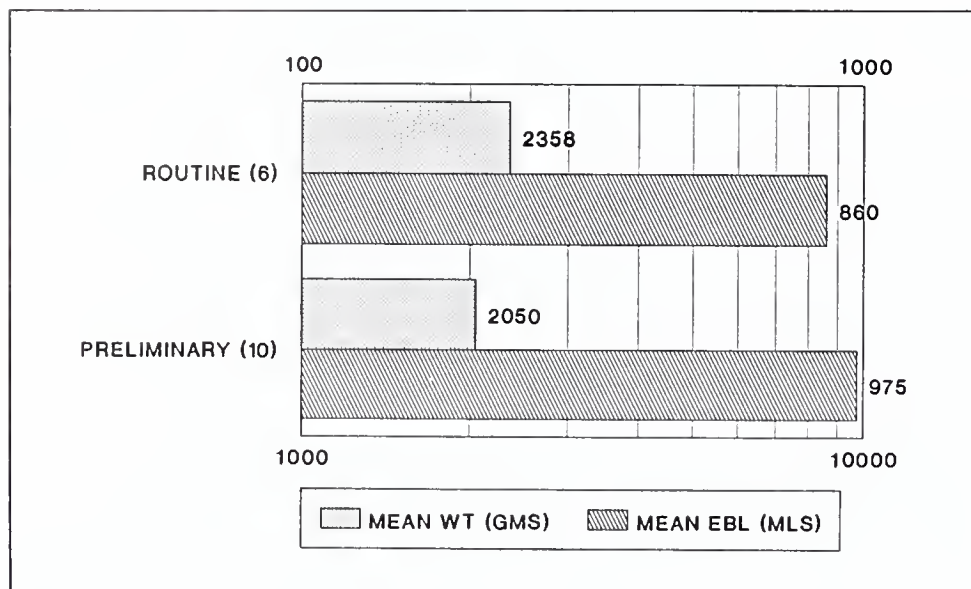


Fig 3 — Splenic Weight and Estimated Blood Loss During Surgery



## Splenectomy for Hematologic Disorders



**Fig 4 — Splenic Weight and Estimated Blood Loss Correlated With Surgical Technique**

2050 gms (Fig 4). In those patients with massive splenomegaly who had routine splenectomy, the mean estimated blood loss was 860 ccs with a mean splenic weight of 2358 grams (Fig 4).

**Table 1. Minor Complications in 59 Patients Undergoing Splenectomy**

Complication	Number
Separation of skin edges	1
Ascites	1
Pleural effusion	2
Atelectasis	3
Urinary tract infection	4
Total:	11
11 complications in 7 patients	(12%)

**Table 2. Major Complications in 59 Patients Undergoing Splenectomy**

Complication	Number
Small bowel obstruction	1
Pulmonary infiltrates	2
Pneumonia	3
Acute renal failure	2
Death	2
Total:	10
10 complications in 6 patients	(10.2%)

Seven patients had drainage of the left upper quadrant with a variety of sump, closed suction, and penrose drains. None of these patients experienced post-operative bleeding or abscess.

There were 11 minor complications in seven patients (11.9%), and 10 major complications in six patients (10.2%) (Tables 1 and 2). Major complications included a small bowel obstruction in one patient, pulmonary infiltrates associated with respiratory insufficiency in two patients, pneumonia in three patients, acute renal failure in two patients, and death in two patients (Table 2). The overall mortality rate for the entire group of 59 patients was 3.4%.

### Discussion

Experience at the Baptist Hospitals of Louisville with splenectomy for hematologic disorders encompassed a wide spectrum of diagnoses. Patients with hematologic malignancies made up the largest number of patients requiring splenectomy. These malignancies included Hodgkin's and non-Hodgkin's lymphoma, hairy cell leukemia, and chronic lymphocytic leukemia. Indications for splenectomy in patients with hematologic malignancies were either for staging, as in all of the Hodgkin's patients, primary therapy, as in the patients with hairy cell leukemia, or to manage complications of the malignancy. These complications included symptomatic splenomegaly, pancytopenia, and thrombocytopenia or post-treatment splenic abscess.

Addressing the miscellaneous disorders, all of the patients with immune thrombocytopenic purpura underwent splenectomy to manage refractory thrombocytopenia after a trial of medical therapy. In this group, splenectomy was required to manage a variety of disorders, including myelofibrosis.

The diagnoses of patients correlated highly with the mean splenic weight in each of the six groups. This reflected the indication for splenectomy and the underlying disease process. Patients with immune thrombocytopenic purpura typically had very small spleens as did those with Hodgkin's lymphoma. Patients with hairy cell leukemia, non-Hodgkin's lymphoma, and chronic lymphocytic leukemia all underwent splenectomy to manage their malignancy or its complications. These spleens were typically large.

Splenic weight also showed a high correlation to the amount of blood loss during surgery. As the splenic weight increased, so did the esti-

mated blood loss.

Patients with massive splenomegaly, (spleens > 1000 gms), experienced more than twice the estimated blood loss as those with spleens weighing less than 1000 grams. Other authors have advocated preliminary ligation of the splenic artery during the course of splenectomy in patients with massive spleens reporting statistically significant reductions in the transfusion requirement at surgery.<sup>1,2</sup> However, in the 16 patients with massive splenomegaly we analyzed, preliminary ligation of the splenic artery was performed in ten, and was not associated with decreased blood loss.

The use of drains in the left upper quadrant was not associated with intra-abdominal abscess or bleeding in this study. Although only seven patients had drainage of the left upper quadrant (12%), we conclude that drainage following splenectomy does not increase the risk of postoperative complication.

There were 11 minor complications in seven patients (11.9%), and 10 major complications in six patients (10.2%) distributed among a variety of indications for splenectomy and blood loss at surgery (Table 3). Three of 16 patients with massive splenomegaly sustained 5 of the 10 major complications. One death occurred in a patient with massive splenomegaly (6.3%). It is worth noting that both deaths in this series were thought to be the result of progression of the patient's underlying hematologic malignancy rather than the direct result of splenectomy.

When comparing our postoperative morbidity, 11 minor and 10 major complications in 13 patients (22%), we found this to be well within the range reported by other groups (13.5% to 75%).<sup>3-6</sup> The mortality rate of 3.3% for the overall group and 6.3% in patients with massive splenomegaly is low when compared to the literature (1% to 18%).<sup>3-6</sup> The authors hypothesize that this low morbidity and mortality is the result of careful selection of patients for splenectomy by experienced hematologists.

## Conclusions

Our analysis demonstrates that the surgeon is likely to encounter a broad spectrum of hematologic disorders for which splenectomy is required. Management of a hematologic malignancy with splenectomy accounted for the majority of patients in this study. Greater splenic weight was directly associated with a greater blood loss during surgery. Preliminary splenic artery ligation

**Table 3.** Distribution of 21 Complications in 13/59 (22%) Patients Undergoing Splenectomy

Indication	Weight (GMS)	Minor	Major
ITP	24	1	
ITP	243	1	
Hodgkins	162	2	
ITP	200	2	
Splenic infarct	200	1	
Splenic abscess	220	1	2
ITP	240	1	
Hodgkins	310		1
Hodgkins	375		1
Non-Hodgkins	865		1 (died)
CLL	2210		1
CLL	2500		2 (died)
Myelofibrosis	3500	2	2
Total: 13 patients		11	10

during the course of splenectomy did not reduce the blood loss during surgery for patients with massive splenomegaly. Further, drainage of the splenic bed was not associated with intra-abdominal abscess or bleeding. The low morbidity and mortality rates in this series of patients support the practice of splenectomy in the community hospital setting.

**ACKNOWLEDGEMENTS:** The authors wish to thank Marge Armstrong and Jan Michino of the Baptist Hospital East Tumor Registry for their invaluable assistance.

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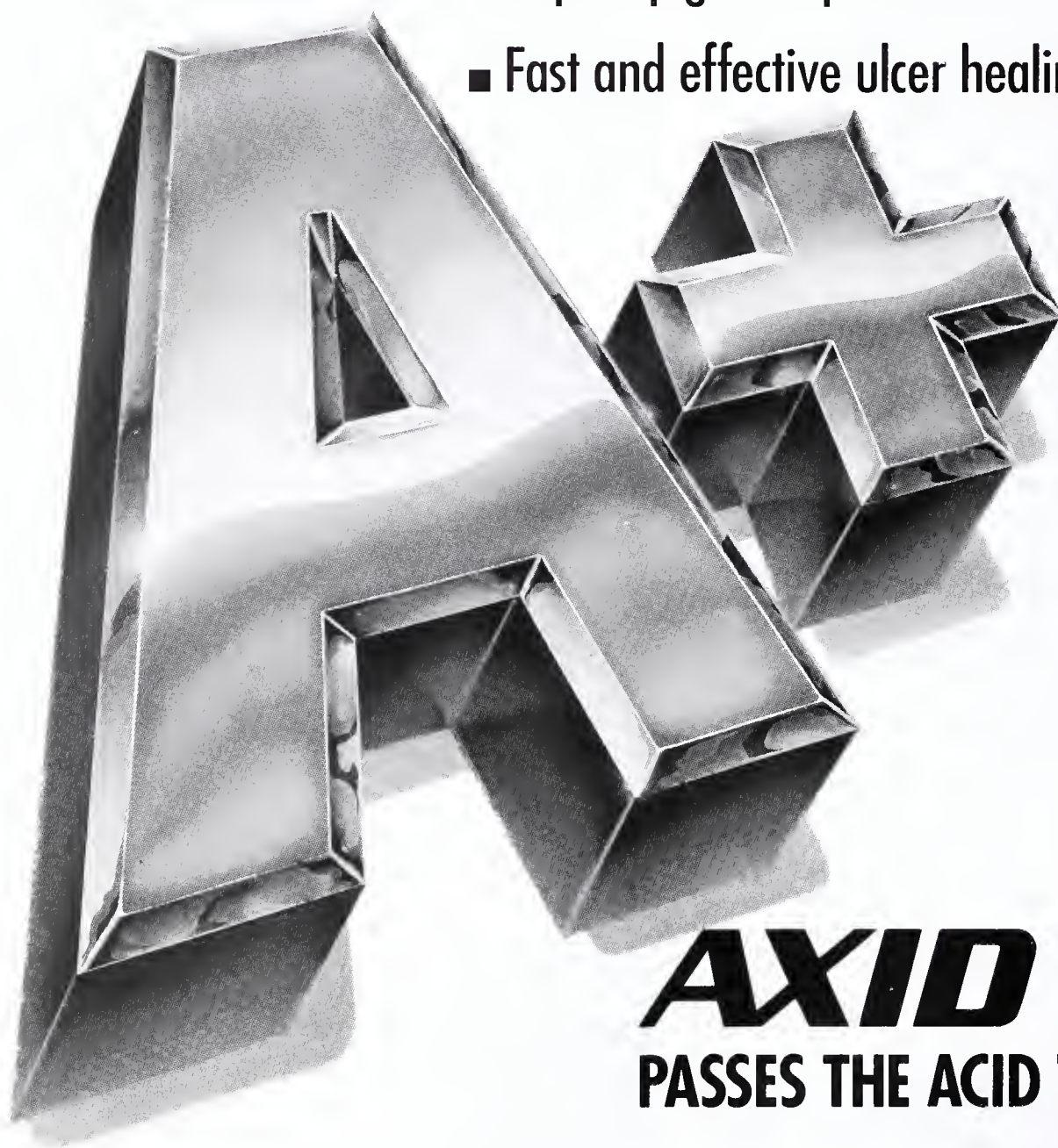


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**Carcinogenesis, Mutagenesis, Impairment of Fertility**—A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, prenatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

**Pregnancy—Teratogenic Effects—Pregnancy Category C**—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

**Nursing Mothers**—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

**Pediatric Use**—Safety and effectiveness in children have not been established.

**Use in Elderly Patients**—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

**Adverse Reactions:** Clinical trials of varying durations included almost 5,000 patients. Among the more common adverse events in domestic placebo-controlled trials of over 1,900 nizatidine patients and over 1,300 on placebo, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common with nizatidine. It was not possible to determine whether a variety of less common events were due to the drug.

**Hepatic**—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

**Cardiovascular**—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

**CNS**—Rare cases of reversible mental confusion have been reported.

**Endocrine**—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to nizatidine. Impotence and decreased libido were reported with equal frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

**Hematologic**—Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H<sub>2</sub>-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

**Integumental**—Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

**Hypersensitivity**—As with other H<sub>2</sub>-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

**Other**—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

**Overdosage**—Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis does not substantially increase clearance of nizatidine due to its large volume of distribution.

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# Indications and Uses of the Noninvasive Vascular Laboratory: Cerebrovascular and Venous Evaluation

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*Noninvasive vascular laboratory tests are highly accurate in diagnosing cerebrovascular arterial and extremity venous disease. These tests can also locate and grade the severity of the disease. Noninvasive studies are preferable to invasive angiographic procedures for the initial evaluation of patients who may have carotid artery disease, deep venous thrombosis, or venous valvular insufficiency. Arteriography of the extracranial cerebrovascular arteries should be used only for operative candidates who have severe disease of the carotid artery as determined by noninvasive studies. Venography is indicated in the few cases in which tibial vein thrombosis cannot be excluded by the noninvasive tests, or in patients undergoing evaluation for venous surgery (valvuloplasty or valve transplant).*



## Introduction

The noninvasive vascular laboratory is the principle diagnostic arena for the evaluation of extracranial cerebrovascular disease. The evaluation of the patient with a neck bruit, transient ischemic attack, or stroke should include the noninvasive vascular laboratory study of the carotid arteries. Stroke or transient ischemic attack secondary to cerebrovascular disease is associated with stenotic or ulcerative lesions at the carotid bifurcation due to atherosclerotic disease. With a high degree of accuracy, noninvasive tests of the cerebrovascular system can either locate and quantitate the severity of disease or exclude its presence in the carotid artery.

These tests are also vital in the evaluation of the patient suspected of having a deep venous thrombosis or venous valvular insufficiency. The diagnosis of venous disease based on only patient history and a physical examination is unreliable

up to 50% of the time.<sup>1</sup> Noninvasive vascular laboratory evaluation of the venous system should be performed whenever the following are suspected: deep venous thrombosis, recurrent deep venous thrombosis, chronic venous insufficiency, superficial thrombophlebitis, varicose veins, venous stasis dermatitis and ulcerations, or pulmonary embolism. The noninvasive evaluation can accurately identify venous valvular insufficiency and thrombosis in the superficial and deep venous systems.

The key to the successful use of the noninvasive vascular laboratory for the cerebrovascular and venous systems is to have the referring physician with a clear understanding of the clinical usefulness of these testing procedures. The basic methodology, indications, and uses of the noninvasive vascular laboratory tests for the evaluation of cerebrovascular and venous disease are described herein.

## Indications and Uses

Noninvasive assessment of the patient suspected of having disease of the cerebrovascular or venous systems enhances the clinical assessment by quantitating the hemodynamic severity of these conditions. Information about the disease is detected, located, and quantitated, and these findings are necessary in determining the proper method of treatment. The noninvasive vascular laboratory tests for cerebrovascular and venous diseases are classified into categories of direct and indirect methods (Table 1). These direct tests of the artery or vein analyze the length, location, and severity of the disease. The indirect tests quantitate the severity of the vascular disease reflected in measurements taken from vessels adjacent to the diseased vessels.

## Cerebrovascular System

**Color-Flow Duplex Scanning** — This is the test of choice in evaluating any patient, symptomatic or asymptomatic, suspected of having extracranial cerebrovascular disease (Table 2). Color-flow duplex scanning is superior to arteriography, which only gives anatomic information without data on the hemodynamics of blood flow.<sup>2</sup> Symptomatic patients should have color-flow duplex scanning of the carotid artery (Fig 1) when the following is present: transient ischemic attack, amaurosis fugax, reversible ischemic neurologic deficit, stroke in evolution, or complete stroke. Symptomatic patients with significant stenosis or ulceration of the carotid bifurcation that is identified by color-flow duplex scanning should undergo arteriography in preparation for carotid surgery. Patients with a normal carotid artery or with internal carotid artery occlusion that is identified by these noninvasive studies are not candidates for surgery. Consequently, they avoid the inherent risks that are involved with the procedure of contrast angiography. Patients with nonhemispheric symptoms, such as dizziness and syncope, can also be evaluated for carotid or vertebral artery disease. The direction of blood flow and disease of the vertebral arteries can be detected with color-flow duplex scanning. The reversal of direction of vertebral artery blood flow is suggestive of subclavian steal syndrome, which is most commonly associated with a proximal subclavian artery stenosis.

Color-flow duplex scanning is also indicated for the evaluation of asymptomatic patients. Patients with an asymptomatic neck bruit are at risk of having a carotid artery stenosis and should undergo this procedure. It is especially useful to screen patients with a carotid bruit before undergoing a major surgical procedure. Color-flow duplex scanning is also useful in following the progression of atherosclerotic disease in patients with known carotid artery stenosis. Follow-up of asymptomatic patients with known carotid artery stenosis is important because the progression to greater than 80% stenosis is highly correlated with the development of transient ischemic attack, stroke, or internal carotid artery occlusion.<sup>3</sup>

When used intraoperatively, color-flow duplex scanning can help the surgeon analyze the technical result of carotid endarterectomy. Failure to detect and correct technical errors can predispose a patient to a stroke after such surgery. Post-

**Table 1.** Noninvasive Vascular Laboratory Tests for the Evaluation of Cerebrovascular and Venous Diseases

Type	Methodology	Indications
<b>Cerebrovascular</b>		
Direct	Color-flow duplex scanning	Carotid bruit, TIA,* RIND,† and Stroke
Indirect	Oculoplethysmography Supraorbital Doppler	Monitor disease progression Surveillance after carotid endarterectomy
<b>Venous</b>		
Direct	Color-flow duplex scanning	Swollen leg Varicose veins Venous stasis dermatitis/ulcerations
Indirect	Doppler survey Impedance plethysmography Phatoplethysmography	Valvular insufficiency Deep venous thrombosis Pulmonary embolism

\*TIA = transient ischemic attack; †RIND = reversible ischemic neurologic deficit.

**Table 2.** Color-flow Duplex Scan Criteria for the Evaluation of Stenosis of the Internal Carotid Artery

Diameter of Reduction	Criteria
Less than 15%	Peak systolic velocity less than 125 cm per second; spectral broadening only during late systole.
15% to 49%	Peak systolic velocity less than 125 cm per second; spectral broadening throughout systole.
50% to 75%	Peak systolic velocity greater than 125 cm per second; end diastolic velocity less than 125 cm per second.
76% to 99%	Peak systolic and end diastolic velocity greater than 125 cm per second.
100%	No flow in the internal carotid artery.

operative follow-up with color-flow duplex scanning permits the analysis of recurrent carotid stenosis and the progression of the disease on the contralateral side.

**Methodology.** Color-flow duplex scanning is a combination of ultrasound (B-mode image of the tissues), Doppler blood flow waveform analysis (processed with a Fourier transformer), and blood flow displayed through a color image (color-coding the frequency changes). The B-mode ultrasound is transmitted, absorbed, and reflected by tissues of various densities; this is reproduced on the gray scale display. The Doppler flow analysis displays over time a frequency amplitude in gray scale. The combination of B-mode ultrasound and Doppler flow analysis allows for the



## Noninvasive Vascular Laboratory

accurate determination of the blood flow velocity. Color-flow duplex scanning allows for the following: rapid identification of the vessel, analysis of the entire length of the vessel for abnormalities in blood flow, display of the direction of blood flow, and illumination of the data from each pixel or sample volume in the B-mode image (Fig 1). The direction of flow is color-coded, whereby the flow towards the probe is indicated in red and the opposite flow is indicated in blue. The amount of color saturation is proportional to the velocity of the red blood cells. Thus, increased velocities and changes in direction of flow are represented by different colors. Anatomic defects can be located through a decrease in color saturation, sudden differences of color of the B-mode image of the vessel, or a mosaic of colors representing turbulent flow.<sup>2</sup>

The test is performed with the patient in the supine position with the head slightly turned away from the side studied. The common, internal, and external carotid arteries should be examined for both B-mode imaging and Doppler spectral analysis. Imaging of the carotid arteries should be obtained in multiple plane views of the transverse and longitudinal axes. Doppler spectra should be obtained from the common, external, and proximal and distal internal carotid arteries. Stenotic lesions are best assessed by recording the most abnormal spectra just distal to the lesion.

*Oculopneumoplethysmography (OPG) and Supraorbital Doppler* — These are indirect tests of the cerebrovascular system. The OPG and supraorbital Doppler respectively assess ocular and supraorbital hemodynamics as an indirect indication of significant proximal extracranial carotid arterial lesions. The OPG accurately detects a hemodynamically significant carotid artery stenosis by measuring alterations in the ophthalmic systolic pressure of the right and left eye. The supraorbital Doppler detects a hemodynamically significant lesion by identifying a reversal of the blood flow direction in the supraorbital artery. The interpretation of the test becomes more complex in the presence of a bilateral, high-grade carotid stenosis. Relative contraindications to the use of the OPG include history of eye disease (ie, glaucoma, amaurosis fugax), eye trauma, or eye surgery. These indirect tests are indicated to confirm a high-grade stenosis or occlusion of the internal carotid artery that had been detected by duplex ultrasonography.

**Methodology.** An OPG is performed by the

application of a focal-negative pressure of 300 to 500 mm Hg to the sclera of the eye with a vacuum cup, which results in a temporary cessation of blood flow. The vacuum pressure is then released, and the pressure at which the pulsations return to the eye is measured and recorded. The test is performed on both eyes and the brachial pressure is measured in both arms. A formula using the ophthalmic systolic pressures of both eyes and both brachial systolic pressures is used to interpret the pressure differences.

The supraorbital Doppler test is performed with an 8 to 10 MHz ultrasound, direction-sensing, pencil-type probe to identify the amplitude and direction of blood flow in the supraorbital or supratrochlear artery as they exit the orbit. The probe is coupled to the skin over the inner canthus of the eye with gel, and a strip chart recorder produces the waveform record for analysis. A minimum of five pulsations should be recorded to determine the amplitude and direction of blood flow. The test is repeated with compression of the branches of the ipsilateral and contralateral external carotid arteries.

### Case Report

While undergoing evaluation for cholecystitis, a 65-year-old hypertensive male was noted as having an asymptomatic right cervical bruit. A duplex scan of the carotid arteries identified a 50% to 75% stenosis of the right internal carotid artery and a normal left internal carotid artery. After the patient underwent cholecystectomy without any complications, he was prescribed one aspirin per day for the asymptomatic cerebrovascular disease. A follow-up duplex scan of the carotid artery 1 year later showed that the right internal carotid artery stenosis had progressed to a 75% to 99% stenosis. The hemodynamic significance of this asymptomatic stenosis was confirmed by an OPG study, which documented a significant reduction of the right ophthalmic systolic pressure as compared with the left. The increased risk of stroke as a result of the progression of the disease to a high grade carotid artery stenosis was explained to the patient, and carotid arteriography was performed in preparation for carotid endarterectomy.

### Venous System

The Doppler (hand-held, continuous wave) is a simple, noninvasive test that can be used at the bedside to assess venous blood flow.<sup>4,5</sup> Venous blood flow is best heard with the Doppler positioned over the posterior tibial vein at the ankle,

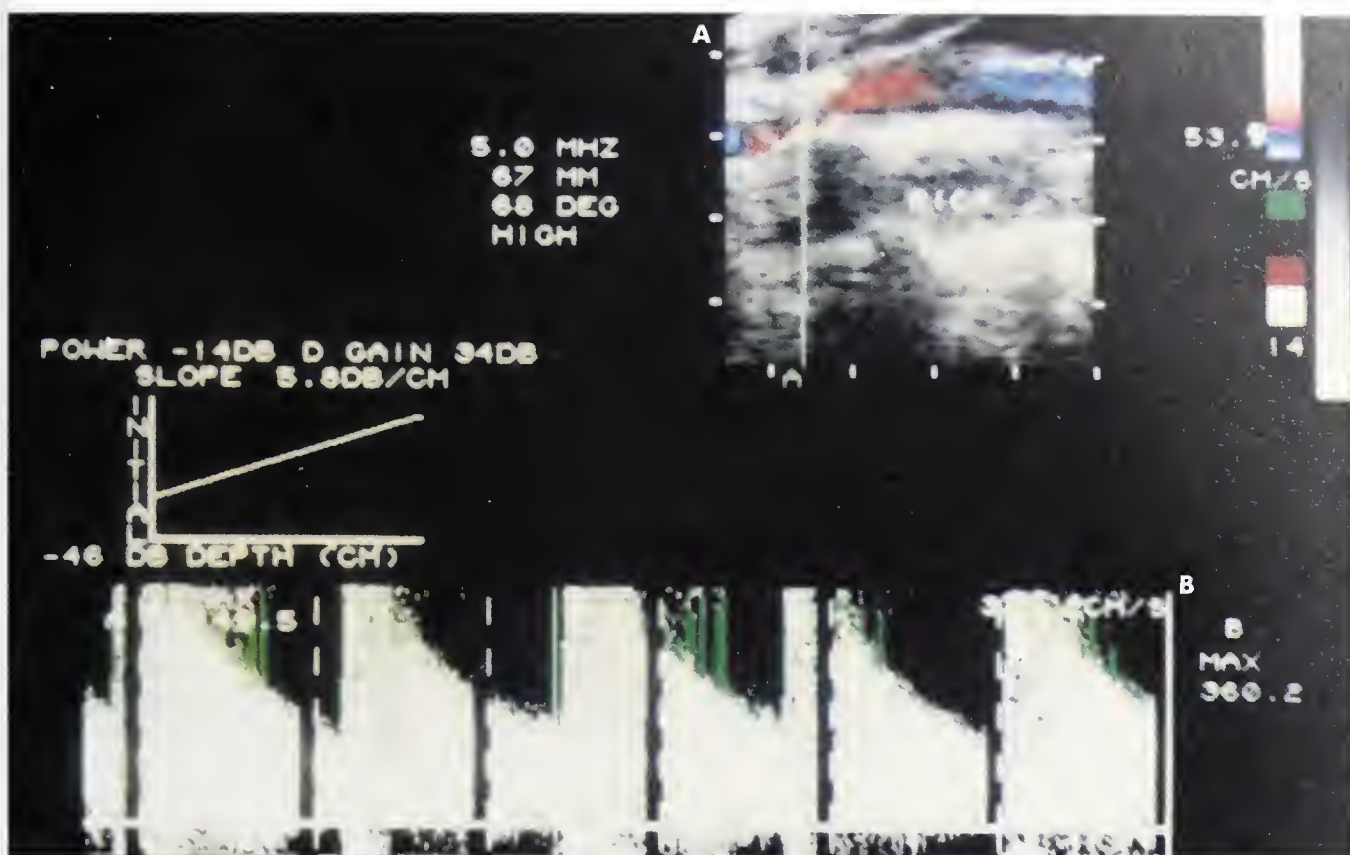


Fig 1 — Color-flow duplex scanning of the right internal carotid artery (RICA). Imaging (A) shows a high grade stenosis of the artery depicted in red. Spectral analysis (B) was consistent with a 76% to 99% stenosis of the right internal carotid artery with peak systolic and diastolic velocities greater than 125 cm per second (maximum = 360.2 cm per second).

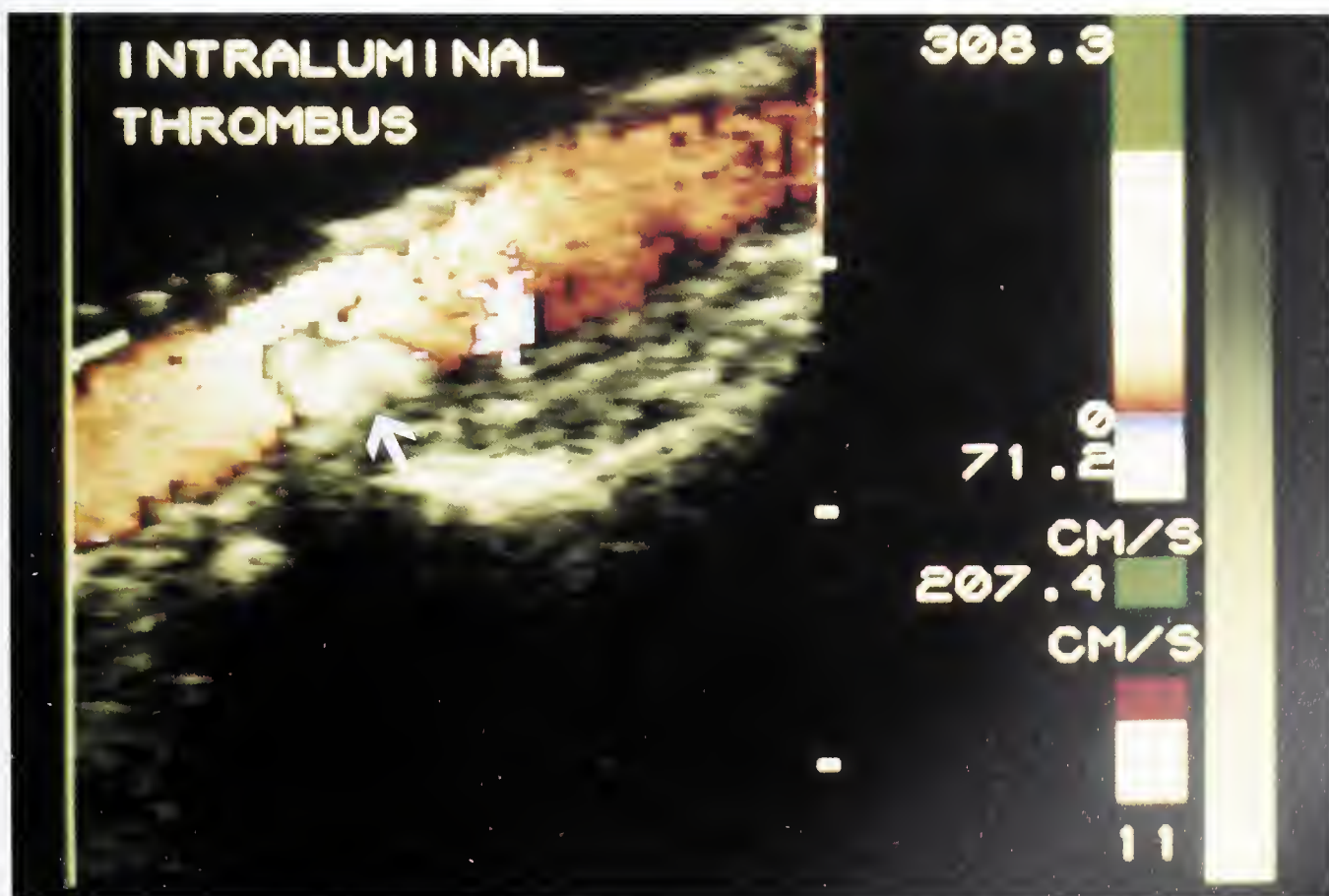


Fig 2 — Color-flow duplex scanning shows blood flow (red) around a partially occluding intraluminal thrombus (arrow).



## Noninvasive Vascular Laboratory

the popliteal vein behind the knee, and the common femoral vein in the groin. Venous flow is normally continuous, phasic with respirations, and augmented by distal compression of the leg. The absence of venous flow at any of these sites is indicative of deep venous thrombosis. However, the presence of venous flow does not exclude the possibility of a deep venous thrombosis because collateral and recanalized veins can yield audible venous blood flow. Valvular competence can also be assessed by compressing the leg proximal to the vein over which the Doppler is positioned. Augmentation of blood flow with the proximal compression of the leg is indicative of valvular incompetence in a distal vein.

**Methodology.** The Doppler test is performed with the patient in the supine position, with the legs in a dependent position and slightly flexed at the hip and knee. The continuous wave Doppler probe is coupled to the skin with acoustic gel and held at a 60-degree angle. The femoral, popliteal, and tibial veins of the lower extremity and the cephalic, brachial, axillary, and subclavian veins of the upper extremity can be examined in this fashion. The venous blood flow signals for each of these locations can be identified by first locating the normal arteries adjacent to these veins. At each location, the venous blood flow should be assessed in respect to the following: spontaneity, phasicity with respiration, augmentation with distal compression, cessation of flow with proximal compression, and augmentation of flow with the release of proximal compression. Superficial veins and tibial veins may have no detectable spontaneous flow, but may also still be normal.<sup>6</sup>

**Color-Flow Duplex Scanning** — This test is indicated for all patients who are suspected of having had venous disease. B-mode imaging of the venous system can assess the presence of intraluminal thrombus, the compressibility of the veins, and the structure of the valves. The addition of color-coding to the procedure has greatly enhanced the accuracy of the examination of the deep venous system, especially of the tibial veins. Doppler flow analysis can assess the phasicity, augmentation, and direction of venous blood flow. Color-flow duplex scanning is superior to venography, which gives no data concerning the hemodynamics of venous blood flow. When scanned with color-flow duplex imaging, normal veins are shown to have smooth walls, compressibility, phasic and spontaneous blood flow, and no ech-

ogenic mass. Color-flow duplex scanning can reliably identify a partially occluding thrombus (Fig 2) or a total venous occlusion of the deep and superficial veins of the lower and upper extremities. Venous thrombosis is diagnosed by the presence of an incompressible vein, an echogenic mass, or no Doppler venous flow with compression by hand of the distal leg. Also, variation of venous blood flow is absent during respiration. Venography is indicated only in those few cases in which a tibial vein thrombosis cannot be excluded by color-flow duplex scanning or in patients undergoing evaluation for venous surgery. Color-flow duplex scanning is highly accurate in identifying a thrombosis in the jugular, subclavian, axillary, brachial, iliac, femoral, mesenteric, portal, and popliteal veins.

Color-flow duplex scanning is also useful in identifying venous reflux of the lower extremities due to valvular insufficiency. The valves of the veins can be identified directly and examined for competency by analyzing the direction of blood flow during Valsalva's maneuver or by applying proximal compression to the leg. Incompetent valves can also be identified within the perforating veins that connect the deep and the superficial venous systems.

**Methodology.** The color-flow duplex scanning test is performed with the patient in the supine position. The head of the scanner is coupled to the skin with acoustic gel. As stated earlier, the veins can be localized by first finding the arteries adjacent to them. The major veins of the neck, arms, and legs can be evaluated with this procedure. The popliteal vein is best examined with the patient in the prone position. Each vein is examined longitudinally and transversely for the presence of an intraluminal mass, compressibility, and flow characteristics. The blood flow in the major veins is assessed for augmentation by compressing the leg by hand, or by deep breaths taken by the patient to increase the venous blood flow return to the heart.

**Venous Plethysmography** — This is an indirect test of the venous system. Impedance plethysmography, an adjunct to color-flow duplex scanning, documents any physiologic impairment of the venous blood flow return caused by a deep venous thrombosis. Plethysmographs measure volume changes related to the amount of blood in the vein. The plethysmograph produces a tracing that reflects the rate of volume change from thigh cuff inflation (causing temporary venous oc-

clusion) and thigh cuff deflation. This results in the subsequent decrease of calf volume as venous blood flow returns. Venous thrombosis is correlated with the slow emptying of the veins of the extremity during cuff deflation.

**Methodology.** Impedance plethysmography is performed with the patient in the supine position, legs relaxed and slightly elevated, flexed at the knees. The transducer is applied to the calf, and the pneumatic cuff is applied to the thigh. The thigh cuff is inflated to cause venous occlusion. The subsequent increase in the size of the calf is recorded by the plethysmograph. After the tracing stabilizes, the thigh cuff is deflated and the venous emptying time is recorded on the plethysmograph. The test is repeated until consistent tracings are obtained.

**Photoplethysmography** — This is used for patients suspected of having a superficial or deep valvular insufficiency. This test assesses valvular competency by measuring the refilling time of the veins of the extremity. A refilling time of less than 20 seconds is indicative of venous valvular insufficiency. The relative contributions of the superficial and the deep venous systems to the valvular insufficiency of the extremity can be assessed by temporarily occluding the superficial venous system by applying a tourniquet above the level of the transducer. If the venous refilling time is normal (greater than 20 seconds) with the tourniquet inflated but less than 20 seconds with no tourniquet occluding the superficial venous blood flow, the valves of the deep venous system are competent. In this instance, the valvular insufficiency of the extremity is due to an incompetent superficial venous system. The differentiation between superficial and deep venous valvular insufficiency is significant because patients who have only superficial valve incompetence can be effectively treated with superficial vein stripping and/or ligation. The plethysmographic tests accurately identify and quantify the physiologic effect of any deep venous thrombosis and venous reflux due to valvular insufficiency.<sup>6, 7</sup>

**Methodology.** Photoplethysmography for valvular insufficiency and reflux is performed with the patient sitting or standing. The photosensor is placed on the skin with double-stick tape 10 cm above the medial malleolus. Changes in calf size are recorded during and after exercise. The relative contribution of the superficial and deep venous systems to the reflux of the extremity can be determined by the application of a tourniquet

to the thigh and above the level of the photosensor.

### Case Report

A 55-year-old male was presented with a 6-month history of right calf and ankle swelling. The left leg was normal. A Doppler examination showed a normal spontaneous, phasic blood flow of the posterior tibial, popliteal, and femoral veins that was augmented with distal leg compression. The patient also had evidence of reflux of the popliteal and posterior tibial veins during proximal compression of the leg. Color-flow duplex scanning of the right leg showed recanalized venous blood flow through partially occluded superficial femoral and popliteal veins due to a previously undiagnosed, chronic, deep venous thrombosis. Impedance plethysmography identified normal venous outflow through the recanalized and collateral veins. Photoplethysmography identified a rapid venous refilling time of the right leg, which did not normalize during the application of a thigh tourniquet to temporarily occlude the superficial veins. These results indicated that the swelling of the patient's leg was due to valvular insufficiency of the deep veins following a deep venous thrombosis. The patient was treated with a compression stocking, but was returned to the hospital in 6 months with a medial malleolar venous stasis ulcer. The results of subsequent impedance and photoplethysmography studies were unchanged from the earlier tests. Color-flow duplex scanning showed the presence of more collateral vessels of the deep venous system and the presence of incompetent perforating veins. The patient underwent ligation of the perforating veins with subsequent healing of the venous stasis ulcer.

### Summary

Noninvasive vascular laboratory tests enhance the clinical assessment of patients evaluated for carotid arterial and venous disease. Patients with a cervical bruit, or symptoms consistent with carotid artery disease, should be evaluated with color-flow duplex scanning. The presence of severe stenosis or occlusion of the carotid artery can be confirmed with OPG or the supraorbital Doppler. Asymptomatic patients with mild atherosclerotic disease of the carotid artery, who are not candidates for operation, can be monitored for progression of stenosis with color-flow duplex scanning. The early and late success of carotid endarterectomy, as well as the condition of the



contralateral carotid artery, can be determined with color-flow duplex scanning. Color-flow duplex scanning is the primary test for those patients suspected of having deep venous thrombosis. Indirect tests can be used to confirm these findings and also to assess the physiologic impairment due to thrombosis or valvular insufficiency of the deep and superficial venous systems. The results of the noninvasive vascular laboratory tests can be relied upon to accurately provide the needed information to make the diagnostic and therapeutic decisions necessary for the care of patients with cerebrovascular or venous disease.

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**Action:** Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

**Indications:** Yocon<sup>®</sup> is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

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**Adverse Reactions:** Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral  $\alpha$ -adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.<sup>1,2</sup> Also dizziness, headache, skin flushing reported when used orally.<sup>1,3</sup>

**Dosage and Administration:** Experimental dosage reported in treatment of erectile impotence.<sup>1,3,4</sup> 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.<sup>3</sup>

**How Supplied:** Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

### References:

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# Delegate's Report

## 1991 Annual Meeting of the House of Delegates

**T**he AMA House of Delegates met in Chicago June 23-27, 1991.

- There were 438 delegates seated initially and the House voted to seat the following four additional specialty societies, bringing the total voting delegates to 442.
  1. American Medical Directors Association
  2. Society of Cardiovascular and Interventional Radiology
  3. Society of Critical Care Medicine
  4. American Orthopaedic Foot and Ankle Society
- The delegates agenda contained 106 reports and 263 resolutions.
- The elections for AMA officers, trustees, and council members were held Wednesday, June 26 (see table).

A wide variety of issues were considered in socio-economics, science and public health. Following are the major issues considered at the meeting:

### **The New Medicare Physician Payment System (RBRVS)**

The beginning of the transition to a new Medicare payment system will culminate nearly a decade of efforts to reform Medicare's physician payment system. From the start, the AMA has played a leadership role. The AMA has viewed Medicare adoption of an RBRVS-based payment schedule as a means of preserving fee-for-service as a viable Medicare option, and has used its support for such a system to defeat proposals for

physician DRGs or widespread capitation for Medicare, as well as to fend off even more severe proposed budget cuts than those actually enacted since 1984.

AMA support was also a major factor in the adoption of key elements of the 1989 payment reform provisions. The AMA played a leadership role in the design of the new system, and has continued this role by developing workable approaches to many implementation issues, advocating adoption of policies that serve the best interests of the entire medical profession, and opposing those that would harm physicians or patients. This report clearly establishes the AMA's intention to maintain its leadership position throughout the implementation process.

The AMA is optimistic that, with the active support of the Federation, the proposed conversion factor cut can be reversed. If it is, as a result of the RBRVS and geographic adjustments, Medicare payments will increase for many physicians. For others, these changes, as well as new limiting charges, will produce payment decreases. Current projections suggest, however, that if the proposed reduction in the monetary conversion factor can be overcome, most physicians will either benefit from or be relatively unaffected by these changes. In addition, the move to a more standardized payment system, in and of itself, with limits on geographic variation and no specialty differentials, will play a major role in

determining the impact on individual physicians.

All physicians will benefit from the simplicity and standardization of the new system and, regardless of how remaining policy issues are resolved, it is clear that RBRVS-based payment schedule continues to be the best Medicare payment alternative of those proposed. To strengthen AMA's advocacy efforts and maintain the Association's leadership role in payment reform, the House adopted the following policies:

1. That the AMA reaffirm its policies in support of an RBRVS-based Medicare indemnity payment schedule (95.021 and 95.016). However, failing appropriate adjustments in the RBRVS payment methodologies for Medicare, the AMA Board of Trustees be given the authority to withdraw AMA support of implementation of the RBRVS.
2. That the AMA strongly oppose reductions in the payment schedule conversion factor due to volume offset assumptions and spending increases resulting from the transition formula.
3. That the American Medical Association carefully evaluate and use caution in support for any wider program use of either the RBRVS or the new Medicare physician payment system until the conversion factor reductions are reversed and until there is an acceptable level of Medicare experience with this new system; and that the AMA produce a current evaluation of RBRVS and



## Delegate's Report — 1991 AMA Annual Meeting

the new Medicare physician payment system to ensure that reimbursements for physicians are equitable, appropriate and adequate, with a report back at the 1991 Interim Meeting.

4. That the AMA oppose any further public program use of either the RBRVS or the new Medicare physician payment system until the conversion factor reductions are reversed and until there is an acceptable level of Medicare experience with this new system.
5. That the AMA continue to work productively with HCFA on such issues as revision of visit and consultation codes, RVS updating, and other elements of the pending Medicare physician payment system.
6. That the AMA embark on a major campaign (the Payment Reform Education Project) to educate physicians and their organizations about the new Medicare payment system, and that the Board report back to the House on its status at the 1991 Interim Meeting.
7. That the AMA monitor the transition to the new system and report back at each Interim and Annual Meeting of the House during the transition.

### HIV Testing

The issue of testing for AIDS occupied a major portion of the delegates debate and received widespread attention from the public media.

The House adopted important policy positions regarding routine HIV testing, testing for health care workers and patients, and testing for prisoners:

- Hospitals, clinics and physicians may adopt routine HIV testing based on their local circumstances. Such a program is not a substitute for universal precautions. Local considerations may include:
  - likelihood that knowledge of a

patient's serostatus will improve patient care and reduce HIV transmission risk;

- prevalence of HIV in patients undergoing invasive procedures;
- costs, liabilities, and benefits;
- alternative methods of patient care and staff protection available to the patient.
- Routine HIV testing should include appropriately modified informed consent and modified pretest and post-test counseling procedures. The Board of Trustees will develop a simplified, modified informed consent form by 1-91. Informed consent should include the following information:
  - patient option to receive more information and/or counseling before deciding whether or not to be tested;
  - patient should not be denied treatment if he or she refuses HIV testing, unless knowledge of HIV status is vital to provide appropriate treatment; in this instance, the physician may refer the patient to another physician for care.
- All negative test results should be provided in a confidential manner accompanied by information on the meaning of these results and the offer, directly or by referral, of appropriate counseling.
- All positive HIV results should be provided in a confidential face-to-face session by a professional properly trained in HIV post-test counseling and with sufficient time to address the patient's concerns about medical, social, and other consequences of HIV infection.
- When an individual presents to a physician with concerns about possible exposure to HIV or when a history of high risk behavior exists, full pretest and post-test counseling procedures should be utilized.
- State medical associations should be encouraged to review and seek modification of state laws that restrict the ability of hospitals and

other medical facilities to initiate routine HIV testing programs.

### HIV Testing for Health Care Workers and Patients

RESOLVED, That the American Medical Association support HIV testing of physicians, healthcare workers and students in appropriate situations; and be it further

RESOLVED, That the AMA study the issues related to such testing including specifying situations in which testing should be performed, the frequency of testing, and the relationship of such testing to licensure, professional liability insurance, granting of privileges or any credentialing process with report back at 1-91; and be it further

RESOLVED, That the AMA supports the position that HIV testing be done on physicians, other health care workers, and patients consistent with testing for other infections and communicable diseases; and be it further

RESOLVED, That the AMA encourage education of patients and the public about the limited risks of iatrogenic HIV infection.

### Testing for Prisoners for HIV Infection and Tuberculosis

- Testing for HIV infection and tuberculosis should be mandatory for all inmates in federal and state prisons.
- During incarceration prisoners should be tested for HIV infection as medically indicated or upon their request.
- All inmates and staff should be screened for tuberculosis infection and retested at least annually. If it is noted that there is an increase in cases of tuberculosis or HIV infection, more frequent retesting may be indicated.
- Testing for HIV infection and tuberculosis should be mandatory

for all prisoners within 60 days of their release from prison.

- During their post-test counseling procedures, prison medical directors should encourage HIV-infected inmates to confidentially notify their sexual or drug-using partners.
- That correctional medical care must, as a minimum, meet the prevailing standards of care for HIV-infected persons in the outside community at large. Prisoners should have access to all approved therapeutic drugs and generally employed treatment strategies.

In other actions, the House of Delegates voted policies to guide the American Medical Association's future activities:

#### **Assistants at Surgery**

- That the American Medical Association oppose any effort by Medicare or any other third party payer to limit payment for medically necessary care, especially in the area of assistants at surgery;
- That the AMA support and participate in as appropriate, the efforts of state and specialty societies to develop guidelines for appropriate use of physicians as assistants at surgery;
- That the AMA continue to oppose and seek regulatory and/or legislative relief from the discriminatory downgrading or elimination of Medicare payments for assistants at surgery.

#### **Geographic Adjustment Factors — Geographic Practice Cost Index (GPCIs)**

- That the AMA support efforts to improve the accuracy of proxies for practice cost components used for geographic cost adjustments in the new Medicare payment schedule

through use of the 1990 census data, an improved measure of office rents costs, and development of equipment and supply costs measures.

- No data are available to support a change in the AMA's current policy that geographic payment variations under a Medicare physician payment schedule should reflect only valid and demonstrable differences in physician practice costs, especially professional liability insurance premiums, with further adjustments as appropriate to remedy demonstrable patient access problems in specific geographic areas.
- That the AMA support the Physician Payment Review Commission (PPRC) approach and general recommendation to replace the current Medicare payment localities with statewide localities, except in states with high intrastate cost variation, and that the AMA support the Health Care Financing Administration (HCFA) proposal that states in which physicians overwhelmingly support a change to a statewide locality be so changed. However, the PPRC approach may require refinement based on analysis of cost outlier counties and other factors.
- That the AMA encourage, and actively engage in monitoring the effects of the new payment schedule, and the effects of the geographic adjustment formula in particular, on access of Medicare beneficiaries and all others to medical care services.
- That the American Medical Association be commended for its leadership on the issue of improving the geographic practice cost indices (GPCIs).
- That, if GPCIs are implemented on January 1, 1992, the AMA request Congress to evaluate the effect of geographic adjustments on access to Medicare services after the first year of implementation.

#### **Equitable Reimbursement for Young Physicians**

- That the American Medical Association maintain passage of HR 1898, a bill to amend the Social Security Act to repeal reduced Medicare reimbursement for new physicians, as a top rank legislative priority;
- That the American Medical Association urge state medical societies and national medical specialty societies to join with it in actively seeking cosponsors for HR 1898 and introduction and cosponsorship of a Senate companion bill.

#### **Bush Administration Professional Liability Proposal**

- That the American Medical Association commend the Bush Administration for its legislative efforts designed to achieve medical liability reform;
- That the AMA support the elements of legislative proposals introduced in the 102nd Congress which are consistent with Association policy, including: (1) limitations of \$250,000 or lower on recovery of noneconomic damages; (2) the mandatory offset of collateral sources of plaintiff compensation; (3) a decreasing, sliding scale regulation of attorney contingency fees; (4) periodic payment of future awards of damages; and (5) a limitation on the period for suspending the application of state statutes of limitations for minors to no more than 6 years after birth.

#### **Restricting Communication between Physicians and Patients**

- That the American Medical Association strongly condemns any interference by the government or other third parties that causes a physician to compromise his or her medical judgment as to what



## Delegate's Report — 1991 AMA Annual Meeting

information or treatment is in the best interest of the patient;

- That the American Medical Association, working with other organizations as appropriate, vigorously pursue legislative relief from regulations or statutes that: (1) prevent physicians from freely discussing with or providing information to patients about medical care and procedures; or (2) interfere with the physician-patient relationship.

**National Practitioner Data Bank**

- That the American Medical Association urge the Department of Health and Human Services to retain an independent consultant (1) to evaluate the utility and effectiveness of the National Practitioner Data Bank, (2) to evaluate the confidentiality and security of the reporting, processing, and distribution of Data Bank information, and (3) to provide the findings and recommendations to the National Practitioner Data Bank Executive Committee and the General Accounting Office;
- That the AMA take appropriate steps to have Congress repeal Section 4752(f) of the Omnibus Budget Reconciliation Act of 1990 requiring peer review organizations and private accreditation entities to report any negative action or finding to the Data Bank;
- That the AMA oppose any legislative or administrative efforts to expand the Data Bank reporting requirements for physicians, such as the reporting of a physician who is dismissed from a malpractice suit without any payment made on his or her behalf, or to expand the entities permitted to query the Data Bank such as public and private third party payors for purposes of credentialing for reimbursement;
- That the AMA seek to amend the Health Care Quality Improvement

Act of 1986 to allow a physician, at the time the physician notifies the Data Bank of a dispute, to attach an explanation or statement to the disputed report;

- That the AMA urge HHS to work with the Federation of State Licensing Boards to refine its breakdown of drug violation reporting into several categories;
- That the AMA urge HHS to analyze malpractice data gathered by the Physician Insurance Association of America and recommend to Congress that a threshold of at least \$30,000 for the reporting of malpractice payments be established as soon as possible;
- That the AMA continue to work with HHS to allow physicians an expanded time period to verify the accuracy of information reported to the Data Bank prior to its release in response to queries;
- That the AMA work with HHS and the Office of Management and Budget to reduce the amount of information required on the request for information disclosure form and to improve the design of the form to allow for more efficient processing of information;
- That the AMA continue to work with HHS to improve its mechanism to distribute revisions and clarifications of Data Bank policy and procedures;
- That the AMA review questions regarding reportability to the Data Bank and that periodic updates on reportability issues be provided to the AMA House of Delegates.

**Biomedical Research and Criminal Activism**

- That the American Medical Association work with Congress to establish a uniform method to assure a prompt, unbiased review by scientific peers of federally funded research projects before grant or contract monies can be withheld from any investigator or institution;

- That the American Medical Association work through Congress to oppose legislation which inappropriately restricts the choice of scientific animal models used in research;
- That the American Medical Association support the Facilities Protection Act (S-544 and HR-2407) which makes it a federal crime and similar legislation at state levels to make it a felony to trespass and/or destroy laboratory areas where biomedical research is conducted;
- That the American Medical Association emphasize to Congress and the American public the need for research on trauma that affects Americans of all ages.

**Conclusion**

AMA House meetings provide a unique educational opportunity and I would encourage you to attend and participate. Any member of the Association may present testimony at the Reference Committee hearings and, of course, corridor discussions on the issues provide ample opportunities to get your views across.

If you can't come to the meeting you can still be represented through your delegate. Let your delegation know your opinions. You can also prepare a resolution and request that it be submitted to the House.

Many AMA policies began with an individual physician who had a good idea and coaxed it through the democratic process.

Thank you for giving me this opportunity to present this report.

I will be happy to respond to any questions.

*Submitted by  
Donald C. Barton, MD  
KMA Senior Delegate*

## 1991 Annual Meeting Election Results

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### PRESIDENT-ELECT

John Lee Clowe, MD

### SPEAKER, HOUSE OF DELEGATES

Daniel H. Johnson, Jr, MD

### VICE SPEAKER, HOUSE OF DELEGATES

Richard F. Corlin, MD

### BOARD OF TRUSTEES

Lonnie R. Bristow, MD

Raymond Scalettar, MD

Jerald R. Schenken, MD

Percy Wootton, MD

Mary Ann Contogiannis, MD (Resident)

### COUNCIL ON CONSTITUTION AND BYLAWS

Richard L. Fields, MD

Sidney E. Foster, MD

Debra M. Osterman, MD (Resident)

### COUNCIL ON MEDICAL EDUCATION

Carol A. Aschenbrener, MD

Robert M. Daugherty, Jr, MD (term ending 1992)

Carl G. Evers, MD

Sam A. Nixon, MD

Hugh E. Stephenson, Jr, MD

### COUNCIL ON MEDICAL SERVICE

Perry A. Lambird, MD

William H. Mahood, MD

Kermit L. Newcomer, MD

Mario E. Ramirez, MD

Howard Entman, MD (Resident)

### COUNCIL ON SCIENTIFIC AFFAIRS

Yank D. Coble, Jr, MD

Richard M. Steinhilber, MD

Jack P. Strong, MD

Henry N. Wagner, Jr, MD

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## Glossary of Medicare Terms

**Balance-Billing Limits (BBL).** Replaces Maximum Actual Allowable Charges (MAACs) as limits on what non-participating physicians may charge patients. BBLs will be linked to the Medicare fee schedule rates and by 1993 will limit unassigned charges to 115 percent of the recognized payment levels for nonparticipating physicians.

**Health Care Financing Administration (HCFA).** The federal agency responsible for oversight of the Medicare program. HCFA receives its instructions from Congress, often as broad directives, and implements them through its regional offices.

**Medicare Volume Performance Standard (MVPS).** Established by OBRA '89, it is aimed at controlling the rate of growth of physician expenditures. It targets an "acceptable" annual rate of growth, taking into account inflation, changes in the number of Medicare beneficiaries, technology, inappropriate utilization, and access problems. If the target is exceeded, the conversion factor for the next year is adjusted downward, within limits.

**Physician Payment Reform (PPR).** Enacted by Congress in OBRA '89, it consists of four elements: 1) RBRVS; 2) balance-billing limits to replace MAACs; 3) the fee schedule conversion factor which is updated based on the Medicare Volume Performance Standard; and 4) creation of a new Agency for Health Care Policy and Research to research the effectiveness of medical services and develop practice guidelines.

**Physician Payment Review Commission (PPRC).** Established in 1986 by Congress to advise it on reforming Medicare's payment methods for physicians. It is advisory only; however, it wields considerable influence with Congress.

**Resource Based Relative Value Scale (RBRVS).** A listing of procedures and unit values that serve as the basis for the Medicare fee schedule. Combined with a conversion factor, it indicates what each service or procedure is to be paid relative to others. It is based on physician work and practice costs associated with each service.



# TOUGH, SMART AND YOURS

medical  
economics  
AUGUST 1989

**S**uccessfully defending a brain-damaged baby case is the courtroom equivalent of pitching a no-hitter. Because the "sympathy factor" can add millions to a jury's award, many insurance carriers would rather settle than fight.

Not so the P-I-E Mutual Insurance Co. of Cleveland, Ohio, and the 4-year-old law firm—Jacobson, Maynard, Tuschman & Kalur—that does all its defense work. In 21 brain-damaged baby cases it has defended for the doctor-owned company, its record is a remarkable 19-1-1, the last a hung jury. In 1988, its overall record read 14 wins, 3 losses—all malpractice cases.

There's more to those numbers than luck. "We even legal skill," adds JMT&K founding partner Aaron Jacobson, who was one of Ohio's leading plaintiffs' lawyers before he, Larry E. Rogers, Herbert S. Bell, M.D., and 70 other Cleveland doctors formed PIE in 1975.

"It's the concept behind the firm that makes it work. Physicians specialty panels review every lawsuit to decide whether the defendant deviated significantly from the standard of care. If he did, we pay. If he didn't, we defend. Makes no difference whether it's a \$5,000 or a \$5 million case. We label it No pay. That policy has resulted in a lot of cases being dropped. Perhaps more important, it's

## DON'T YOU WISH THESE DEFENSE LAWYERS WERE YOURS?

This big, multistate firm rarely loses a case. But it's more than luck, or even legal skill, that's behind its enviable record.

By Howard Eisenberg

discouraged the filing of many other cases. Plaintiffs' attorneys have learned that we're fair negotiators when our doctor's in the wrong, but won't back down when he's right."

That approach pays off. "According to the most recent report I've seen from the General Accounting Office," says Larry Rogers, PIE president and CEO, "in 1984, about 57 percent of medical-malpractice claims were closed without payment. Through 1988, we've closed an average of 78 percent of our cases without a dime changing hands. And it's my understanding that, without including defense costs, St. Paul Fire and Marine Insurance Co.'s 1988 average gross payout for cases closed in Ohio with payment was \$52,500. Our comparable figure was about \$10,000 below

theirs. That's partly why we can sell an ORG specialist in Ohio—an industrial state that ranks among the most litigious—\$1.2 million in coverage for just \$26,400."

The unique marriage of PIE and JMT&K has been so successful that the carrier has expanded into five other states: Indiana, Kentucky, Maryland, Missouri, and West Virginia. Where PIE goes, there goes JMT&K, with nine branch offices to date. The firm has 65 trial attorneys, and may well be the nation's largest elevated well-though exclusively to medical-malpractice defense.

Could the insurer-defender symbiosis, if duplicated by other doctor companies, make a significant contribution to reducing malpractice litigation nationwide? An up-close look at

how JMT&K operates may help to answer that question.

### Every lawyer develops a medical specialty

"Our firm's lawyers read more medical books than law books," says PIE Vice President Gerard U. Oppenorth, himself a veteran defense attorney. Robert Maynard explains: "New cases are discussed at our weekly staff meeting so that every lawyer is familiar with every case. But we assign cases to our attorneys according to medical specialty. They're well-versed in their fields, so they don't have to reinvent the wheel with each case."

Last year, the firm's ORG specialist, attorney Jerome S. Kalur, who had won 16 consecutive brain-damaged baby cases, faced one of his toughest challenges when he defended a GP

who'd attempted a midforceps delivery that ended in a Caesar section and a severely brain-injured baby. Recalls Kalur: "I didn't think the doctor had caused the damage, but our position was weakened by the fact that he didn't have midforceps privileges. Based on that departure from the standard of care, our doctor panel voted to settle, and since the hospital was also involved, a combined sum of \$1.5 million was offered. Plaintiffs turned us down flat."

"I wanted to depose the doctors who'd been involved in the mother's care during her hospitalization, but the attorney for the plaintiff baby insisted it would violate the mother's physician-patient confidentiality. That privilege would terminate automatically when her medical

The winning firm's four founders at Cleveland's 9th District Court of Appeals (from left): Jerome S. Kalur, Aaron Jacobson, James M. Tuschman, and Robert Maynard.

records were introduced at the trial end of the plaintiff's case. Meanwhile, I was in the no-win position of having to tell the jury: 'It couldn't have been the midforceps, without offering them another reasonable brain-damage theory.'"

Fortunately, the plaintiffs rested their case on a Friday afternoon, giving JMT&K time for a weekend rally. "Twenty minutes later," says Kalur, "I was in the hospital pathologist's office with an order permitting me to view the mother's placental slides." Meconium staining had been charted, and Kalur had a hunch that fetal distress had begun long before the fir-



**T**hey're seasoned attorneys with an incredible record of success.

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Three-quarters of all claims closed without a penny changing hands.

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LOUISVILLE, KENTUCKY 40222  
502-339-7431

# View-point Based Suppression of Speech in the Practice of Medicine in the United States

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***“If this ‘small’ intervention is valid, what protection do we have against further ‘view-point based restrictions’ imposed upon any physician receiving Medicare dollars? Perhaps next time the government mandated medical opinion and required therapeutic approach will pertain to the use (or denial) of angioplasty, renal transplant, or conversations that may or may not be held when an HIV Titer is ordered.”***

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**O**n May 23, 1991, the Supreme Court of the United States of America issued a ruling that created a small but significant infringement upon physicians' right to free speech. Specifically, the ruling altered physicians' rights to give medical advice to a patient according to his/her professional judgment and substituted a view-point which was required as a condition of employment.

At issue was whether physicians practicing medicine at family planning clinics receiving any federal dollars could be required neither to acknowledge a specific medical alternative nor to refer a patient to someone who could. As such, the key issue was viewed by many to be an abortion versus anti-abortion debate. But, the fact is that the ruling had much greater significance with regard to professional and ethical standards of care by physicians than it did upon the abortion debate. Whether the patient be a pregnant woman seeking abortion as a method for family planning with all the controversy incumbent to such an approach, or a pre-eclamptic diabetic whose life is threatened, the Supreme Court upheld the requirement that physicians may only discuss prenatal care for this woman and may not enter into a discussion of the role termination of her pregnancy may play in her care should certain medical developments occur.

The term for this used by the dissenting justices is “view-point based suppression of speech.” This is

the first time ever that view-point based suppression of speech has become a condition for acceptance of government dollars, according to the dissenting opinion written by Associate Justice Harry A. Blackmun.

The majority opinion takes the view that the right to free speech is not violated, but is simply a condition of employment acknowledged by any person accepting employment at these clinics. If so, Blackmun points out, it is also the first time ever that

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***“Government has always monitored and controlled the actions of physicians, but never our speech.”***

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the Supreme Court has found that our government can require relinquishing a fundamental constitutional right as a condition of employment.

This is the first time that the Supreme Court has specifically upheld actual words that physicians can or cannot use in discussing a patient's medical problem and treatment options. This is the first time that the Supreme Court has dictated to the medical community that it will be deemed unlawful for physicians to discuss treatment options with a



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**“Never before has government intervened in the conversations a professional may have with a client, in this case, a physician with his/her patient.”**

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patient. Government has always monitored and controlled the actions of physicians, but never our speech.

View-point based suppression of speech adversely affects our ethical responsibility to fully discuss treatment options for a patient under our care. A patient who is seeking medical attention in these clinics may be deprived of an accurate discussion of their medical situation and treatment options not to mention their very life should appropriate care or referral be denied them.

It is difficult to evaluate this opinion without focusing strictly on the abortion issue at the heart of this test case. But as physicians we must, because its significance is immense with respect to the role government plays in the practice of medicine. This represents government intervention in the practice of medicine to an unprecedented degree. Never before

has government intervened in the *conversations* a professional may have with a client, in this case, a physician with his/her patient. Never before has government *dared* to impose a medical opinion on the medical profession and hold that it will be unlawful to communicate a contrary view-point.

If this “small” intervention is valid, what protection do we have against further “view-point based restrictions” imposed upon any physician receiving *Medicare* dollars? Perhaps next time the government mandated medical opinion and required therapeutic approach will pertain to the use (or denial) of angioplasty, renal transplant, or conversations that may or may not be held when an HIV Titer is ordered. Think about it.

**Martha Keeney Heyburn, MD**

## Physician Payment Reform

**T**O THE EDITOR: This, the most far reaching reform since the inception of Medicare in 1966, was mandated by Congress to become effective January 1, 1992.

Why CPR (Customary, Prevailing and Reasonable) reform? The present UCR system is cumbersome. It does not provide for uniformity as regards geographic or specialty payments for the same procedure. It is little understood by physician and patient. Perhaps more importantly it has failed, despite all efforts, to curtail the ascending spiral of health care costs. The new method consists of a national fee schedule for all seven thousand CPT-4 procedure codes used by physicians.

Factors to control costs, ensure consumer protection and to take into account geographic cost differentials in running a practice are built into the system. A great many details of this system are not clear, settled, or decided. Nothing this complex,

affecting so many special interests, is going to be easy, done without pain, or settled within a defined time frame.

There is an attempt here at social engineering. Congress, in its wisdom, has decided that "cognitive" CPT-4 procedure codes (those carried out by internists and family physicians) have not been reimbursed sufficiently. The so-called procedural tasks where something is done have been "overpaid." The new system is designed to "correct" these perceived inequities. The early published amounts: 30% increase for cognitive, 40% decrease for surgeons; are already diluted. If one reduces a few high money CPT-4 procedure codes (not used at tremendous frequency) and adds this money to codes utilized in the millions, one is not going to raise the latter much without unacceptably great reductions in the former. Yet, the entire process is planned to be "budget neutral."

In an attempt to soften economic

impact, the system will be phased in over a 5-year period. It is hoped that about 65% of fees will achieve their level the first year. The remainder will find the new level, either up or down, at the rate of 15% per year.

The deductible will remain in effect. The coinsurance methodology will remain intact. The participating/non-participating plan will be unchanged. The cost of practice and the cost of medical liability insurance are factored in by geographic area. Kentucky remains with three geographic areas.

The resource based relative value scale of all the codes (7000) has been determined by Dr Hsaio and his group at Harvard. These results have been received with hosannas or cries of anguish depending on one's position in this great game.

**J. B. Holloway, MD**  
Medical Director

## Physician Payment Reform II

**T**O THE EDITOR: In the May Update, your Medical Director had some remarks on Physician Payment Reform which was basically a simplified version of what HCFA is trying to do in conjunction with the carrier. In the short time-interval since then, this office has been deluged with preparatory studies and instructions to prepare the way for Physician Payment Reform. These instructions are not pertaining to what you, as providers, must do but what we, as the carrier, must do.

Beginning January 1, 1992, we will be paying claims under two systems. All claims with dates of service prior to January 1, 1992, will be paid under the old geographic Usual and Customary Fee system. All dates of service from January 1, 1992,

will be paid under the new fee for service system Relative Value Scale.

So, with no increase in personnel, no increase in budget, and no experience under the new system, we will be paying out monies using two systems for every single code in the book. Therefore, not only are the physicians going to be burdened with learning a new system, but we are as well. This office sees a hectic 6 months with many errors, many delays, and many frustrations.

Most of you are going to find your fees reduced and, in addition to that overwhelming bad news, you will probably be faced with an office not able to respond even as well as we have done in the past. I know this is raising your hackles; but try and bring your sense of humor to the fore.

Very shortly, the second stage of the rebundling initiative will go into effect. Some of you may find your fees curtailed because of the rebundling. Although literally hundreds of active physicians in private practices have been consulted in this rebundling initiative, there will most surely still be errors. There may be exceptions to the rebundling, which are reimbursable with documentation.

This office is happy to entertain any appeals you may have when this initiative starts. It will be wise to put them in writing rather than calling me because I expect more than I can handle on an immediate basis.

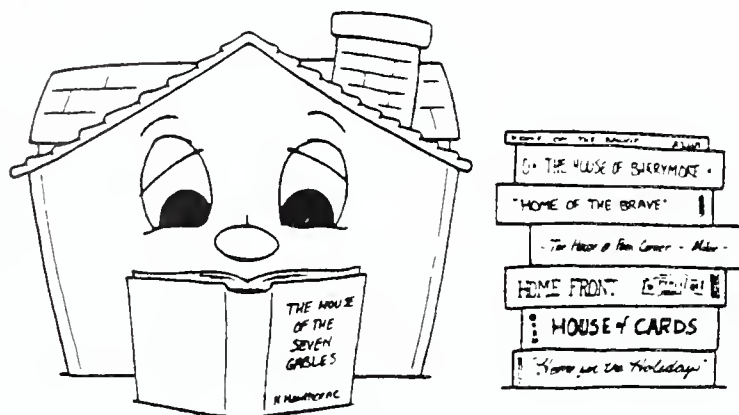
**J. B. Holloway, MD**  
Medical Director



# BOOKS TO YOU

## LOUISVILLE FREE PUBLIC LIBRARY

### HOMEBOUND PROGRAM



*This is a free service through which eligible persons may have Library materials delivered.*

#### **WHO IS ELIGIBLE?**

Any resident of Jefferson County who is physically unable to come to the Library is eligible for this service.

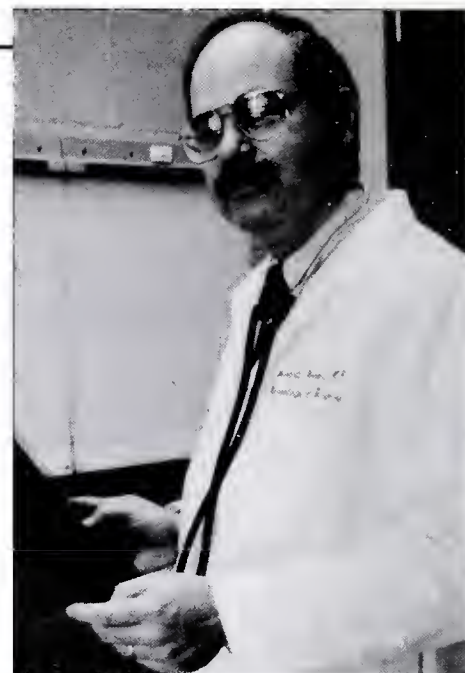
#### **WHEN ARE MATERIALS DELIVERED?**

Once a month, a volunteer will deliver Library materials and accept requests for the next delivery.

#### **WHAT IS AVAILABLE?**

Books, in regular and large print, magazines and audio cassettes.

Please call 561-8603 or 561-8627 or your nearest branch for information or to volunteer.



## Sure...

**you're a good physician,  
but can you write?**

Most physicians today need more than knowledge of medicine and good clinical ability to be successful. One of the tools you need is the ability to write well: to be able to put together a report of research that's worth publishing, to write a grant proposal that's fundable, to prepare a paper or exhibit for presentation that's well received.

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9650 Rockville Pike  
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Address \_\_\_\_\_

Title (or specialty) \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

## WE'VE MOVED !!!!

### KENTUCKY MEDICAL ASSOCIATION

HEADQUARTERS OFFICE

HAS A NEW ADDRESS:

301 N. Hurstbourne Parkway, Suite 200  
Louisville, KY 40222

NEW PHONE:

(502) 426-6200  
FAX - (502) 426-6877

# AKMA *Connections*



**T**he Fall Board Meeting of the Auxiliary to the Kentucky Medical Association will be held in conjunction with the KMA Annual Meeting in Lexington. The meetings will be held at the Hyatt Regency Lexington/Lexington Center.

The Hospitality Suite will be open Monday at 9 AM and registration will begin at 9:30 AM. Committee meetings will be held on Monday, September 30. The Board meeting will be held Tuesday, October 1 from 9 AM to 12 noon.

A luncheon will be held on Tuesday following the Board meeting. Any spouses of KMA attendees are

cordially invited to attend the Auxiliary luncheon. Information on luncheon reservations may be obtained from Jean Wayne, AKMA Executive Secretary, 301 N Hurstbourne Parkway, Suite 200, Louisville, KY 40222, 502/426-6200.

Make an Auxiliary Connection — stop by our booth in the exhibit area. Membership information will be available.

*Sam Blackstone*

**AKMA President**

## FALL BOARD SCHEDULE

### MONDAY, SEPTEMBER 30

9:00 AM-4:00 PM AKMA Hospitality Room Open  
9:30 AM-2:00 PM AKMA Registration  
10:00 AM-1:30 PM Committee Meetings  
6:00 PM KEMPAC Seminar — Patterson Ballroom, Hyatt Regency

### TUESDAY, OCTOBER 1

8:00 AM AKMA Hospitality Suite/Registration  
9:00 AM-12:00 noon Fall Board Meeting  
12:30 PM Luncheon



# KEMPAC

## 29th Annual Seminar-Banquet

*Gubernatorial Candidates*



Brereton C. Jones



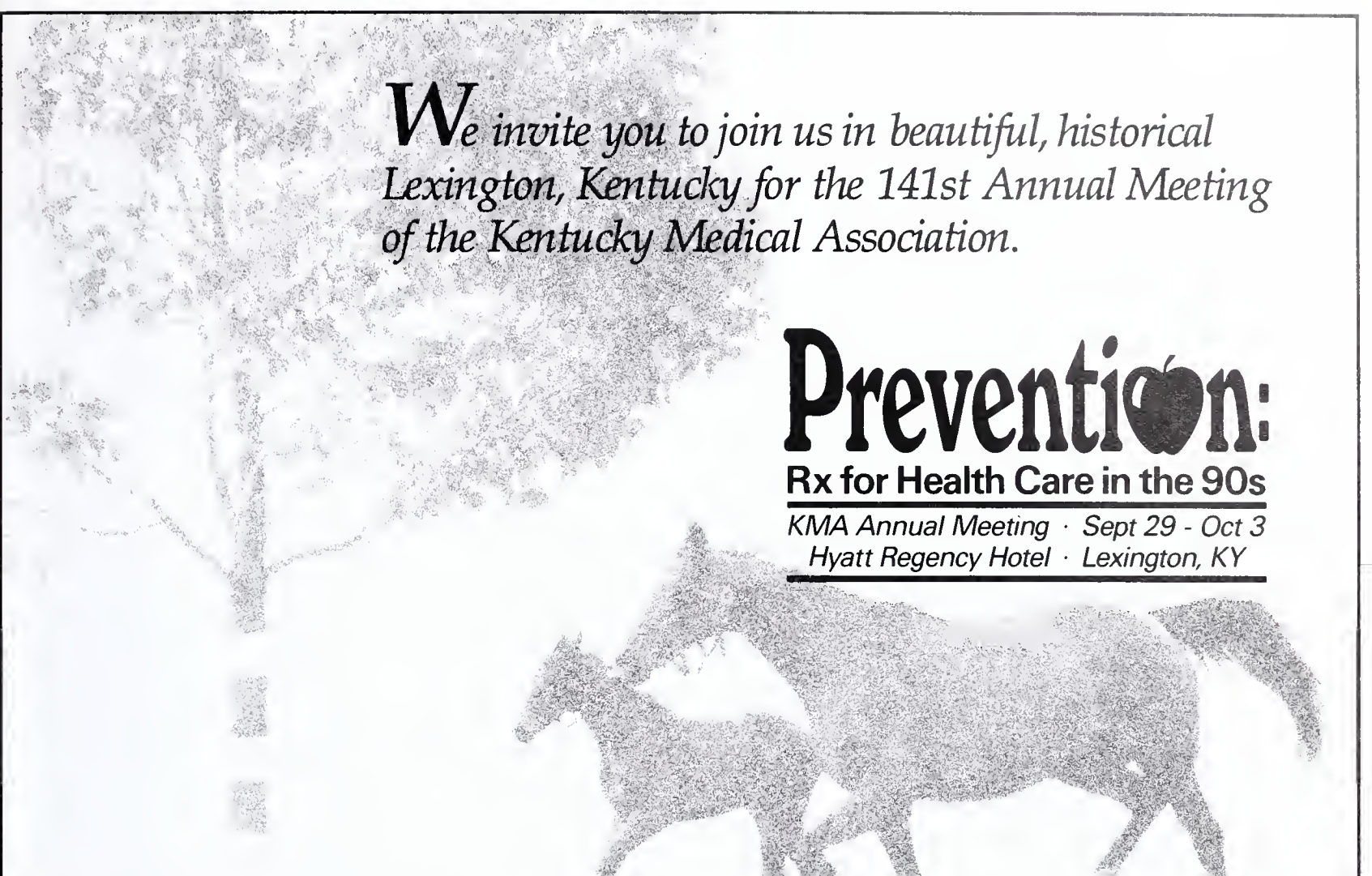
Larry J. Hopkins

*have been invited as our special guests to  
address the seminar*

Monday, September 30, 1991  
6 PM EDT — Reception — Hyatt Suite  
7 PM EDT — Dinner — Regency Ballroom  
(Program to Follow Dinner)  
Hyatt Regency Hotel  
Lexington, KY

**MARK YOUR CALENDAR! ORDER TICKETS NOW!**





**We** invite you to join us in beautiful, historical  
Lexington, Kentucky for the 141st Annual Meeting  
of the Kentucky Medical Association.

# Prevention:

**Rx for Health Care in the 90s**

*KMA Annual Meeting · Sept 29 - Oct 3*  
*Hyatt Regency Hotel · Lexington, KY*

**KEMPAC TICKETS ARE ON SALE NOW!** They can be purchased from the KEMPAC Headquarters Office for \$30.00 each. Make check payable to *KEMPAC* and mail to: KEMPAC, 301 N Hurstbourne Parkway, Suite 200, Louisville, Kentucky 40222

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29th KEMPAC Seminar-Banquet — \$30.00 per person.

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**THE UNITED STATES ARMY RESERVE  
HEALTH CARE PROFESSIONALS  
BONUS TEST PROGRAM  
\$10,000 - \$20,000 - \$30,000**

The **1989 National Defense Authorization Act** required that the Department of Defense conduct a test to determine the effectiveness of a recruitment bonus to attract health care professionals to the Selective Reserve of the Army. The 1991 National Defense Authorization Act directed that the test continue.

The Bonus Test Program is offered to physicians in the following specialties:

**ANESTHESIOLOGY  
ORTHOPAEDIC SURGERY  
and  
GENERAL SURGERY**  
*(Including selected subspecialties)*

Applicants must be board certified or meet all requirements for board candidacy in one of the above specialties.

**BONUS ELIGIBILITY:** In addition to meeting all criteria for appointment as a medical corps officer in the US Army Reserve, Bonus Test applicants must be civilians and if prior service, discharged before 28 April 1989.

**BONUS AMOUNTS:** The test offers \$10,000 bonus for each year of affiliation with the Selected Reserve of the Army, up to a maximum of 3 years. Physicians must choose 1, 2, or 3 years of affiliation at time of application. Bonuses will be paid annually at the beginning of each year of agreed affiliation.

**TEST PARAMETERS:** The design of the test stipulates that bonuses be offered in certain geographic areas. To qualify, applicants must reside within those areas at the time of accession.

**TO FULLY DETERMINE YOUR ELIGIBILITY FOR THIS PROGRAM  
PLEASE CONTACT:**

**U.S. ARMY RESERVE HEALTH CARE TEAM  
9505 Williamsburg Plaza, Washington Building, Louisville, KY 40222  
OR CALL COLLECT: (502) 423-7342 or 7444**

## William B. Monnig, MD, Nominated for KMA President-Elect

**W**illiam B. Monnig, MD, has been nominated by the Northern Kentucky Medical Society Inc for the office of President-Elect of the Kentucky Medical Association.

Dr Monnig's extensive service to KMA began in 1984 when he was elected Eighth District Trustee, a position he held until 1990. From 1987 until 1990, Dr Monnig also served as Chairman of the Board of Trustees, Chairman of the Executive Committee of the Board of Trustees, and as a member of the Quick Action Committee. In 1990 he was elected Vice President of KMA. His commitment to KMA has been apparent through his many committee memberships, with current obligations to the State Legislative Committee, Committee on Medical Insurance, Medico-Legal Committee, Hospital Medical Staff Section, and as Chair of the Building Committee.

A native of Ohio, Dr Monnig earned a BS degree in 1965 and an MD degree in 1969 from the University of Cincinnati. He completed an internal medicine internship at the University of Illinois in 1970, followed by completion of a surgical residency in 1971 and a urology residency in 1974 at the University of Cincinnati. Dr Monnig is a board certified urologist with offices in Edgewood, Ft. Thomas, and Florence, KY, and is also an assistant clinical professor in the Department of Surgery at the University of Cincinnati Medical Center.

Vice President Monnig is or has been affiliated with numerous professional organizations including the American Urological Association; Southeastern Section, A.U.A.; American College of Surgeons, Fellow; AMA; and Northern Kentucky Medical Society. Professional association leadership positions



include serving as a director on the boards of the KMA Insurance Agency, Inc; Cambus-Kenneth Foundation; Northern Kentucky Mental Health Association; and Kentucky Coalition on Nursing.

Dr Monnig and his wife, Donna, have two children and reside in Park Hills.

*kma*



## PEOPLE



Steven L. Salman

The board of directors of Kentucky Medical Insurance Company has named **Steven L. Salman** as president and chief executive officer.

Salman, 43, senior vice president and general counsel for a Cincinnati-based healthcare organization and chief executive officer and director of several affiliates, succeeded President and Chief Executive Officer **Carl L. Wedekind, Jr.**

"Mr Salman has extensive experience in healthcare administration and professional liability insurance, and we believe his skills and knowledge will help Kentucky Medical realize its operating and strategic goals. We're very fortunate to find a person with Steve Salman's talent and experience," said Kentucky Medical Chairman **Richard F. Hench, MD**, who was a member of the executive search committee.

An Indianapolis native, Salman has served on the board of directors of five separate insurance companies.

Jefferson County Coroner and pediatrician **Richard Greathouse, MD**, has been reappointed to the state Sudden Infant Death Syndrome Advisory Committee by the Cabinet for Human Resources.

Louisville plastic surgeon **Joe F. Arterberry, MD**; Jefferson County Medical Society President **Linda H. Gleis, MD**; and **Bonnie S. Roth (Mrs John B.)** were included in the 1991-92 class of Leadership Louisville.

After almost 20 years as a practicing psychiatrist, **Clifford Kuhn, MD**, is going on tour as a comedian. As part of his research on laughter and its effects on health, the University of Louisville School of Medicine professor is taking a 6-month sabbatical to tell jokes professionally.

Kuhn is a regular guest on the WHAS-AM talk show, "Metz Here." He answers questions about psychiatric problems and refers callers to sources of help. His on-air work received the American Psychiatric Association's national Media Merit Award.

**Louise F. Hutchins, MD**, of Berea, who has furthered the cause of family planning in Eastern Kentucky for more than 50 years, was one of five Kentucky women named as winners of the first Kentucky Woman of the Year awards. Presented by the state Commission on Women, the Stovall Awards — in honor of former Lieutenant Governor Thelma L. Stovall — were announced recently at a banquet in Frankfort.

Fifty-seven Kentucky women were nominated, and the New York City Commission on the Status of Women judged the contest based largely on the efforts to improve the status of women in the state.

At its 1991 annual meeting, **Jacqueline A. Noonan, MD**, professor and chairman, Department of Pediatrics, University of Kentucky College of Medicine, was elected to serve a two-year term on the governing body of the National Board of Medical Examiners.

The following KMA member physicians have received staff promotions at the University of

Louisville School of Medicine: **John Buchino**, professor, pediatrics and pathology; **Joseph Hersh**, professor, pediatrics; **Baby Jose**, professor, radiation oncology; **John Karibo**, clinical professor, pediatrics; **Gerald Larson**, professor, surgery; **Bogdan Nedelkoff**, clinical professor, pathology; and **Richard Wright**, professor, medicine.

## UPDATES

## UK Establishes Pisacano Chair of Family Practice

The University of Kentucky Board of Trustees recently accepted a generous gift that completes funding for the **Nicholas J. Pisacano, MD**, Chair in Family Practice in the College of Medicine.

The gift of approximately \$781,000 from an anonymous donor finalizes a fund-raising campaign that began in 1982 to establish an endowed chair in the department of family practice by the Kentucky Academy of Family Physicians. After Dr Pisacano's death March 11, 1990, the American Board of Family Practice ignited the national campaign to name an endowed chair in his honor. This gift brings the balance in the endowment to more than \$1 million.

Dr Pisacano is recognized worldwide as having been an excellent physician and educator. He was founder and executive director of the American Board of Family Practice.

"Nick Pisacano played a key leadership role in the development of family practice as a specialty in the United States. He zealously worked to advance the profession of medicine and education to the highest standards," said **Peter P. Bosomworth, MD**, chancellor for the UK Medical Center.

"The generosity of colleagues

and friends throughout the nation is a great testimony to the love, respect, admiration and high esteem in which Nick Pisacano is held. Some people are bigger than life, and Nick was one of those people. We miss him a lot. We are very grateful to the American Board of Family Practice, the Kentucky Academy of Family Physicians and the hundreds of family practitioners who made this chair possible," said **Emery Wilson, MD**, dean, UK College of Medicine.

"This endowed chair in Nick Pisacano's memory will ensure that his standards of educational excellence and his significant contributions to the development of family practice as a specialty will be perpetuated long into the future," said **Alan David, MD**, chair of UK's department of family practice.

### FDA Approves New Antihypertensive Treatment

The US Food and Drug Administration has granted permission to CIBA-GEIGY Pharmaceuticals to market Lotensin® (benazepril HCl) for the treatment of hypertension. CIBA-GEIGY reports that the new drug, a non-sulphydryl angiotensin-converting enzyme (ACE) inhibitor, effectively lowers blood pressure (both diastolic and systolic), and exhibits important safety benefits for hypertensives age 55 and over.

Information on the product's safety and efficacy in patients over 65 years of age is included in its package insert — one of the first to reflect some of the FDA's new geriatric labeling requirements.

### Merck Drug Approved for Treating Active Duodenal Ulcers

Merck, Sharp & Dohme reports that Prilosec™ (Omeprazole, MSD) has received approval for a new indication from the US Food and Drug Administration for the short-term

treatment of active duodenal ulcers. According to Merck, Prilosec is first in a new class of anti-ulcer drugs with a unique mechanism of action, providing rapid ulcer healing and pain relief in most patients within 4 weeks; it is indicated for short-term treatment of active duodenal ulcers; and it should not be used as maintenance therapy for treatment of patients with duodenal ulcer disease. Introduced by Merck & Co, Inc in 1989, the drug was originally approved to treat certain severe or poorly responsive gastrointestinal diseases.

## NEW MEMBERS

*Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.*

### Bourbon

**Emmett L. Tate, MD** — R  
PO Box 737, Paris 40361  
1974, U of Louisville

### Boyle

**John S. Aumiller, MD** — C  
635 Parksville Crosspike, Danville 40422  
1976, Hahnemann Medical College

**Richard E. Nallinger, MD** — U  
315-A W King Blvd, Danville 40422  
1978, U of Louisville

### Breathitt

**Aaron K. Jonan, MD** — IM  
337 Colb Fork Rd, Jackson 41339  
1986, College of Osteo. Medicine, Kansas City

### Calloway

**H. Casey Hines, MD** — R  
2129 Southwest Dr, Murray 42071  
1985, U of Kentucky

### Clay

**James B. Towry, DO** — GP  
HC 69, Box 700, Beverly 40913  
1985, Kirksville College

### Carlisle

**James A. Whitlock, DO** — GP  
RR 1, Box 25A, Arlington 42021  
1989, Kirksville College

### Daviess

**L. Kendrick Mills, MD** — C  
2816 Veach Road, Owensboro 42301  
1985, Harvard

### Estill

**John A. Patterson, MD** — FP  
115 Main St, Irvine 40336  
1973, U of Tennessee

### Fayette

**James A. Knost, MD** — ONC  
1780 Nicholasville Rd #500, Lexington 40503  
1974, Louisiana State U  
**Barbara Fleming Phillips, MD** — IM  
450 New Circle Rd NE, Lexington 40505  
1982, Wright State

**Christine N. Riley, MD** — R  
One St. Joseph Dr, Lexington 40504  
1975, U of Kentucky

### Greenup

**Shera Mogri, MD** — FP  
105 Hildean Ct, Russell 41169  
1967, B. J. Medical College, India

### Jefferson

**William E. Ackerman, III, MD** — AN  
6807 Fallen Leaf Cir, Louisville 40241  
1976, U of Louisville

**Elizabeth A. Amin, MD** — R  
608 Club Lane, Louisville 40207  
1968, U of Manchester, England  
**Chris N. Anggelis, MD** — C  
4607 Wolf Creek Pkwy, Louisville 40241

1984, U of Louisville  
**Connie P. Anggelis, MD** — C  
4607 Wolf Creek Pkwy, Louisville 40241  
1984, U of Louisville



**Thomas L. Moore, MD** — EM  
3903 Carriage Hill Dr, Crestwood  
40014  
1979, U of Texas

**Chandra Mullangi, MD** — TS  
250 E Liberty #418, Louisville 40202  
1965, Guntur Medical College, India

**Mark Newstadt, MD** — PD  
1668 Almara Circle, Louisville 40205  
1981, U of Witwaterstand, S Africa

**Amul M. Patel, MD** — OTO  
1035 Wall St #206, Jeffersonville, IN  
47130  
1968, M. P. Shah Medical School,  
India

**Walter M. Rose, DO** — AN  
917 Lime Spring Way, Louisville 40223  
1986, Kirksville College

**Elizabeth F. Rouse, MD** — FP  
2128 Strathmoor Blvd, Louisville  
40205  
1987, U of Louisville

**Ennu Surender, MD** — P  
7318 Wesboro Rd, Louisville 40222  
1962, Osmania Medical College, India

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#### Magoffin

**Roger W. May, DO** — GP  
176 Church St, Salyersville 41465  
1989, WV School of Osteopathic  
Medicine

#### McCracken

**Charles B. Ross, MD** — S  
621 N Valley Rd, Paducah 42001  
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**Esther E. Saalfeld, MD** — FP  
5522 Taylor Mill Rd, Taylor Mill 41015  
1986, U of Kentucky

#### New In-Training

#### Fayette

**Donna L. Aubrey, MD** — R  
**Mark E. Bailey, MD** — FP  
**Allen R. Bond, MD** — R  
**Kimerli A. Plumb, MD** — PD  
**William R. Salter, Jr, MD** — OBG

#### Jefferson

**Robert J. Link, MD** — AN  
**Van Q. Nguyen, MD** — IM

#### Kenton

**Montiel T. Rosenthal, MD** — FP

### DEATH

**Eugene M. Holmes, MD**  
**Middletown**  
**1923-1991**

Eugene M. Holmes, MD, a retired general practitioner, died July 19, 1991. Dr Holmes graduated from the University of Louisville School of Medicine in 1949 and was a life member of KMA.

**Robert D. Eastridge, MD**  
**Lebanon**  
**1912-1991**

Robert D. Eastridge, MD, a retired general practitioner, died June 13, 1991. Dr Eastridge was a 1944 graduate of the University of Tennessee College of Medicine and a life member of KMA.

## KMA Member . . . Auxilian . . .

Our readers are interested in the important events occurring professionally in the lives of their fellow members. Do you, or someone you know, have a newsworthy note to submit for possible publication in your *Journal of the KMA*?

If so, please submit in writing to:

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**Suite 200**  
**Louisville, KY 40222-8512**

## SEPTEMBER

**20 — Clinical Update for Ophthalmic Nurses and Technicians**, Radisson Plaza Hotel, Lexington, KY. Contact: Kay Montgomery, The Center for Advanced Eye Surgery, Humana Hospital-Lexington, 150 N Eagle Creek Dr, Lexington, KY 40509; 606/268-3754.

**20-21 — Clinical Advances in Cataract, Glaucoma and Corneal Surgery**, Humana Hospital-Lexington. Contact: Kay Montgomery, The Center for Advanced Eye Surgery, Humana Hospital-Lexington, 150 N Eagle Creek Dr, Lexington, KY 40509; 606/268-3754.

**21 — Corneal-Contact Lens Update 1991**, Radisson Plaza Hotel, Lexington, KY. Contact: Kay Montgomery, The Center for Advanced Eye Surgery, Humana Hospital-Lexington, 150 N Eagle Creek Dr, Lexington, KY 40509; 606/268-3754.

**27-28 — Diabetes and Peripheral Vascular Disease**; Holiday Inn Crown Plaza, Columbus, OH. Contact: The Ohio State University, College of Medicine, Center for Continuing Medical Education, A-352 Starling Loving Hall, 320 W Tenth Ave, Columbus, OH 43210-1240; 614/292-4985.

## OCTOBER

**11 — Practical Diabetes Management Symposium for the Primary Care Physician**, Marriott Griffin Gate Resort, Lexington. Presented by The Diabetes Center of Excellence at Humana Hospital, Lexington. Contact: Kay Montgomery, Humana Hospital-Lexington, 150 N Eagle Creek Dr, Lexington, KY 40509; 606/268-3754.

**27-November 1 — Twenty-Second Family Medicine Review — Session III**; Hyatt Regency Hotel, Lexington, KY. Contact: Ms Joy Greene, Director CME, 132 College of Medicine Office Bldg, U of K, Lexington, KY 40503-0086; 606/233-5161.

## NOVEMBER

**4-8 — 57th Annual Scientific Assembly of the American College of Chest Physicians**, San Francisco Marriott and the Moscone Center, San Francisco, CA. Contact after June 20, 1991: American College of Chest Physicians, Division of Education, 3300 Dundee Rd, Northbrook, IL 60062-2348; 708/498-1400.

**15-16 — 25th Annual Newborn Symposium and 5th Fall Symposium of the Kentucky Pediatric Society**, The Seelbach, 500 Fourth Ave, Louisville, KY. Contact: Lynette McInnis, 502/588-5329.

**16-19 — Southern Medical Association's Annual Scientific Assembly**, Georgia World Congress Center and Atlanta Hilton and Towers, Atlanta, GA. Contact: SMA, 800/423-4992.

## JANUARY 1992

**16-18 — American Academy of Pain Medicine's 1992 Annual Conference**, Registry Hotel, Scottsdale, AZ. Contact: Carol Endicott, American Academy of Pain Medicine, 5700 Old Orchard Rd, 1st Floor, Skokie, IL 60077-1024; 708/966-9510.

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**OCTOBER 1, 2, 3  
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SESSIONS**





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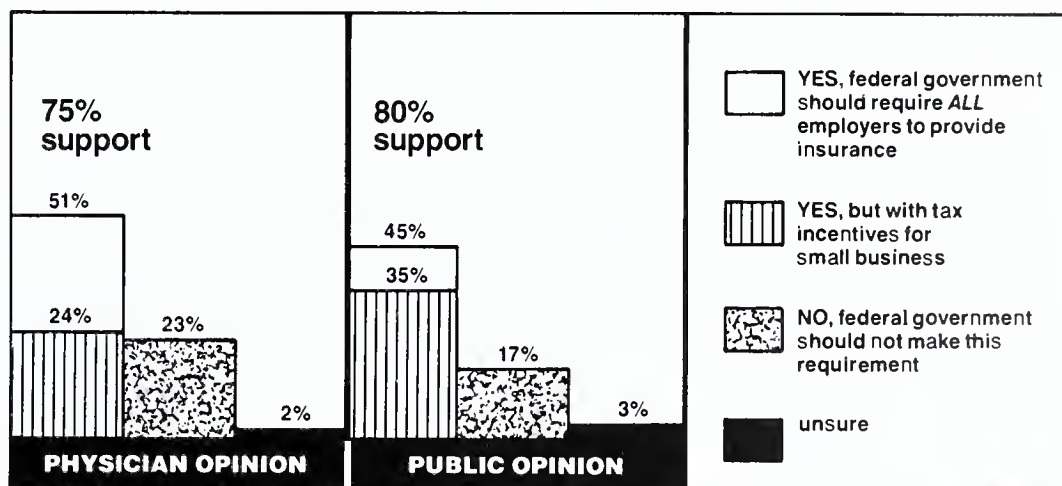
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Sources: Dec. '89 Gallup Survey/Physicians Jan. '90 Gallup Survey/Public

A message from The American Medical Association for the Health Access America Proposal



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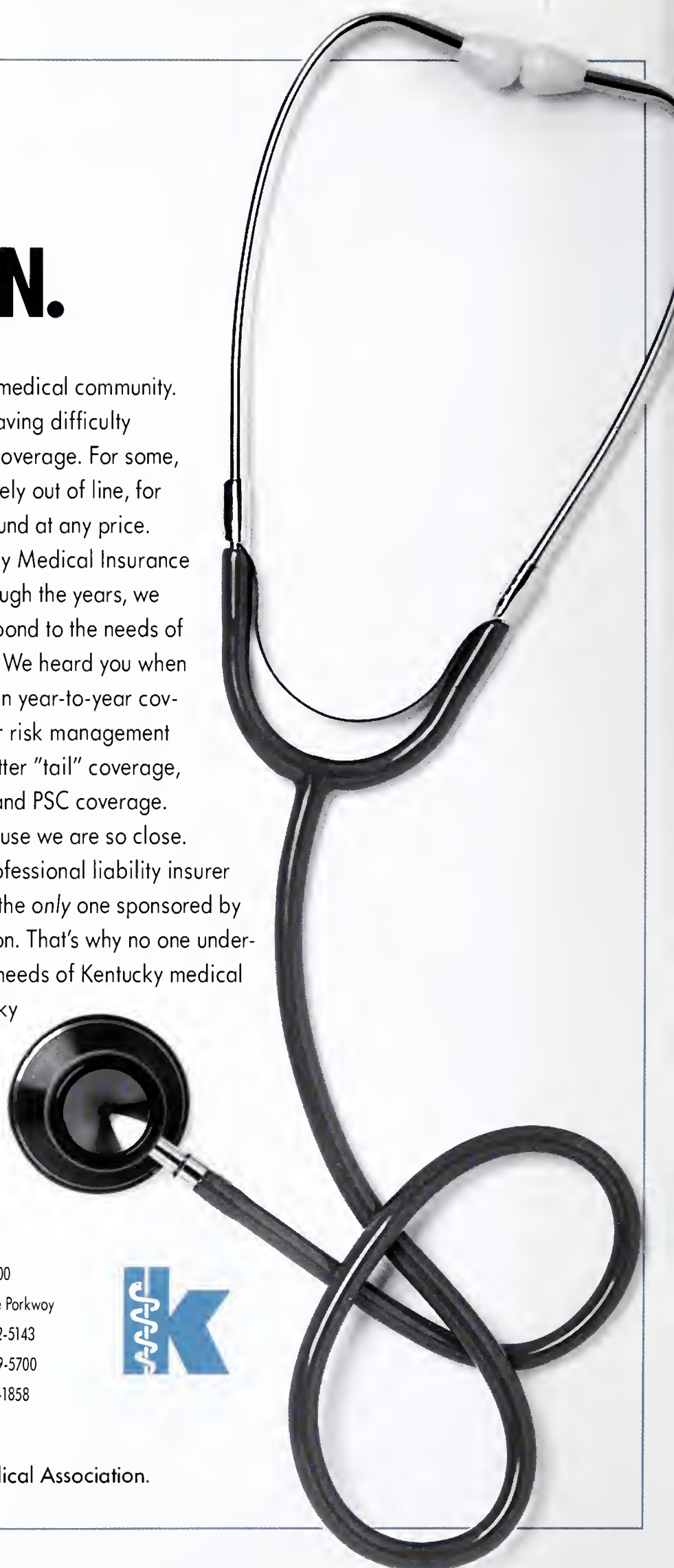
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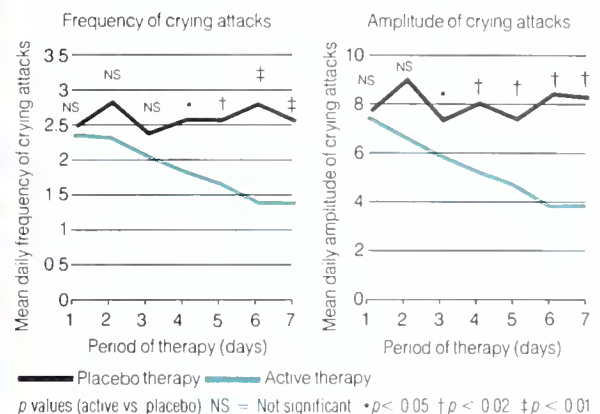
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<sup>1</sup> Kanwaljit SS, Jasbir KS. Simethicone in the management of infant colic. *Practitioner*. 1988;232:508.

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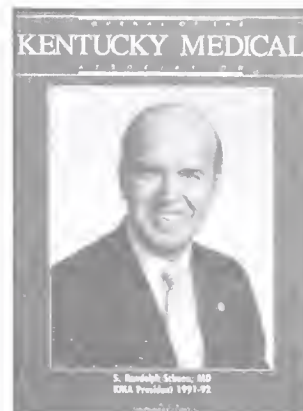
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**KMA**



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## Inaugural Address S. Randolph Scheen, MD

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***“at the very core of controlling health care costs is the theme for this KMA year . . . Prevention . . . or as a television commercial on household furnaces states, “Preventive Maintenance can really save you money.””***

---

**T**here are no words that could express my deep appreciation for this honor you have bestowed upon me. I pray for the strength and wisdom to serve you well in the coming year.

From this vantage point, as Chairman of the Awards Committee, for over 10 years I had the privilege to present to many outstanding physicians KMA's highest award, the Distinguished Service Award. Without exception I always noted a single characteristic that existed among every one of them — their unique devotion to their patients and the profession. All of them truly cared for their patients and felt an obligation to return something back to the profession.

While the KMA has many purposes, its foremost responsibility is to be a guardian for patients. From a public perspective, whether the imagery of painter Norman Rockwell or the writings of George Orwell prevail in the health care arena in the 90s will in a large measure depend

upon our recognition and awareness of patients' needs. Future historians will reflect not only on the modification of the health care delivery system but more importantly upon physicians' reactions to them and their subsequent impact upon patients.

While this may not be an easy time for us, remember it's not an easy time for many of our patients. Millions are uninsured — the vast majority working at minimum wages. Even though government continues to tell us that the economy is on the rebound, it is estimated that 12 million children, our most precious resource, are without insurance. The major cause of bankruptcy for families in America today is due to their inability to pay for health care.

I say these things today, not to be negative, but to place in proper perspective physicians' problems. Dealing with managed care; government insurance; the 1500 health insurance plans; all the problems of RBRVS . . . they all



require our attention and work. But . . . we need to keep our patients foremost in our minds for our delivery system to survive.

However, the system will not survive intact if some of the things that are going on within are not addressed. We read about examples of large profits and salaries by those on the fringes of the system, only indirectly involved. But I'm not here today to speak to those people. We need to evaluate ourselves first if we are to restore the public trust.

The rapid rise in the cost of health care and the public's concern with our future, should give us pause as we establish our fee structures. All health care providers, and that includes those who insure and others who play a role in the system, must be very careful in raising their fees and costs. As noted in a recent article, 50% of the American public are unhappy with the present health care delivery system. However, the greatest concern is that 40% of the American people believe that the present health care system should be dismantled and a new system built. We have to take notice of the results of this poll and begin responding to the public's concern and in some way seek resolution to the cost, delivery, and accessibility of health care.

Health care costs, health care for the uninsured and underinsured, control of the spread of HIV infection, addressing the high cost of care of the elderly in the final years of life . . . like it or not, these are the issues we will be addressing this year both on the national and the state level. I propose to you that at the very core of controlling health care costs is the theme for this KMA year . . . Prevention . . . or as a television commercial on household furnaces states, "Preventive Maintenance can really save you money." The emphasis on diagnosis and treatment and the neglect of prevention are the very basis of our long standing and growing health problems in this

country. For instance, it costs up to \$2,000 a day for the care of a low birth-weight baby . . . but less than \$500 for nine months of prenatal care. Insurance plans will pay thousands of dollars for treating breast cancer . . . but often the \$75 cost of a screening mammogram is not covered. Approximately \$700 million is being spent per year on health care, but a minimum amount is invested in disease prevention and health promotion. For instance, 25% of our preschool children are not fully immunized. There are many areas of prevention in all specialties . . . which

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***“basic medical care should be available to every Kentuckian regardless of where they live. KMA needs to be at the forefront in this battle to prevent further erosion of rural care.”***

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can, and are . . . being addressed at this meeting. It's time for us to put prevention first and direct our energies towards the prevention of disease and disability and the promotion of good health for persons of all ages.

We need to be proponents of peer review systems, especially those which assure quality, cost effectiveness, and restore confidence in the system. The emphasis upon Judicial Council activities and the work of Committees like the Impaired Physicians Committee hold the key to restoration of the public's perception of us. The Board of Medical Licensure

must continue to expand its role to protect the public and the profession in assuring that physicians are fulfilling their roles and maintaining the public trust.

In his presidential address entitled "The Right Road for Medicine," Doctor John Ring, President of AMA, made some observations which I would like to share with you today — and I quote, "Medicine is about taking care of sick people. It's about helping all Americans lead healthier and more productive lives. It's about being good, ethical professionals. And we must preserve, protect, and promote medicine's professionalism. By professionalism, I mean that dedication to competence, compassion, and moral accountability that has characterized the best doctors in every era since Hippocrates. Professionalism is, to us doctors, our very identity as doctors. And the basic act of professionalism is a doctor looking after a patient: **the doctor-patient relationship**. We can accept nothing that threatens this relationship by trying to turn medicine into a mere trade, a dispassionate business venture, an impersonal public utility. We can accept nothing that threatens this relationship by maneuvering us to work for anyone other than our patients. Are we a profession to which business interest is incidental, or are we a business to which our professionalism is incidental? Are we entrepreneurs or servants? Are we providers or healers? Are we vendors or care givers? If we choose the right road, we choose the road of responsible professionalism and personal sacrifice."

Personal relationships between physicians and patients must be improved. Keeping patients waiting unnecessarily in the office or emergency room is indefensible. Polls continue to mirror the harsh criticism the public has toward physicians who fail to recognize that the patient's time is as valuable as the physician's. In

fact, the number one complaint that the average patient makes about his doctor, more often than the cost of health care, is being kept waiting at the office.

Public relations, despite what some may think, will not restore or create long term images for medicine. Norman Rockwell's paintings take us back to a time when a special relationship existed between patients and physicians. We can restore that image by treating every patient in a special manner recognizing that their needs are real and personal. We enhance our image by assuring that medical assistants are trained to recognize that patients pay their salaries and provide them a place to work. Medical care is a special responsibility which requires special people. There is no room in the health profession for impatient and uncaring people. We need to start our office hours on time and be conscious about over-booking. Common courtesy should prevail and patients should be made aware if the physician is delayed and given options in these cases.

As many of you know, I started out in medicine as a family physician in Cloverport, Kentucky, a small community on the Ohio River. Despite many efforts of the government, the public, and physicians, rural health care has now entered into a new crisis. The inequities of government reimbursement in Medicare and Medicaid and the differences paid by private insurers to urban and rural physicians for the same service is outrageous and should not be tolerated. Health planners' goals to regionalize medical care have not worked to benefit rural areas. While we all recognize that some planning of medical resources is necessary, basic medical care should be available to every Kentuckian regardless of where they live. KMA needs to be at the forefront in this battle to prevent further erosion of rural care.

Finally, the real battles of medicine will be determined in the political arena, especially in state legislatures. Only 15% to 20% of physicians take an active role in the political process and our lackadaisical and often condescending approach toward politics needs to be reconsidered. Our fates may well be determined by the Kentucky General Assembly.

Over 100 years ago Oliver Wendell Holmes said, "It is a province of knowledge to speak and a privilege of wisdom to listen." Our patients are speaking to us . . . but

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***“Medical care is a special responsibility which requires special people. There is no room in the health profession for impatient and uncaring people.”***

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they have difficulty in being heard above the clamor of providers, government, insurance companies, and the entrepreneurs.

As physicians, we were taught to listen carefully to patients in order to make a proper diagnosis. We need to pause and listen more to our patients . . . they will ultimately determine our fate and the future of our medical system.

In The Wizard of Oz, you recall —  
the lion wanted courage —  
the tin man was looking for a heart —  
the scarecrow was searching for a brain —  
and Dorothy sought happiness.

In the end, each of them discovered they already had what they were looking for. They simply failed to recognize and use what they possessed. We have the answers to the problems that exist in our society. We simply have to utilize the talents and resources we have at our fingertips. It will require sacrifices on our part . . . but the rewards are great.

If the Wizard of Oz were to grant me several wishes, to aid me in the coming year, I would ask him to instill in me those qualities which have been personified by several Past Presidents. Among these are the strength and integrity of Nelson Rue; the dedication to purpose of Bob DeWeese; and the deep sense of "Pride in Medicine" of Preston Nunnelley. These qualities are necessary for any KMA President to be effective. Even more important, I will need your personal support and encouragement.

---

**Presented by  
S. Randolph Scheen, MD,  
Louisville, as he assumed  
the presidency of the Kentucky  
Medical Association  
on October 2, 1991.**



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Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

**Indications:** Yocon<sup>®</sup> is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

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**Adverse Reactions:** Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.<sup>1,2</sup> Also dizziness, headache, skin flushing reported when used orally.<sup>1,3</sup>

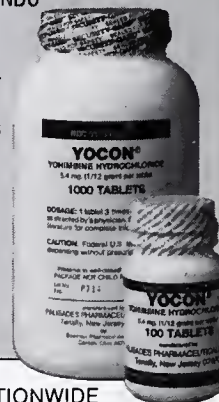
**Dosage and Administration:** Experimental dosage reported in treatment of erectile impotence.<sup>1,3,4</sup> 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.<sup>3</sup>

**How Supplied:** Oral tablets of Yocon<sup>®</sup> 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

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# Glioblastoma Multiforme Occurring in a Patient Following Exposure to Polychlorinated Biphenyls

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From the Division of  
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Louisville, KY.

*Polychlorinated biphenyls have been shown to be carcinogens in animal studies. Because of lipid solubility and lack of biodegradation, they are known to deposit preferentially in fat and nervous tissue. In this report, we describe a 31-year-old male with prolonged polychlorinated biphenyls exposure who developed glioblastoma multiforme. Fat biopsy documented the presence of markedly elevated PCB levels. A co-worker also developed a malignant astrocytoma. The nature of PCBs and their role in human carcinogenesis are discussed. The possibility of an etiologic link between PCBs and brain tumors should be further investigated.*

## Introduction

A number of chemical compounds have been known to induce various types of brain tumors<sup>22</sup> (Table 1). Certain industrial occupations have been found to be associated with an increased prevalence of primary brain malignancies.<sup>10, 20</sup> These occupations have included workers in oil refinery and petrochemical production, the nuclear power and electrical industries, polyvinyl chloride production, and synthetic rubber manufacturing.<sup>14</sup>

Polychlorinated biphenyls (PCBs) are lipid-soluble chemicals which are known carcinogens in animals.<sup>7, 24</sup> To our knowledge, they have not been previously linked to human brain tumors. In this paper, we describe a case of a glioblastoma multiforme occurring in a 31-year-old Caucasian male. The patient, while employed as an electrician for a gas pipeline company, worked 12 years in an area that was discovered to have high levels of PCBs. Fat biopsy, done independently, showed elevated PCB levels to be present.

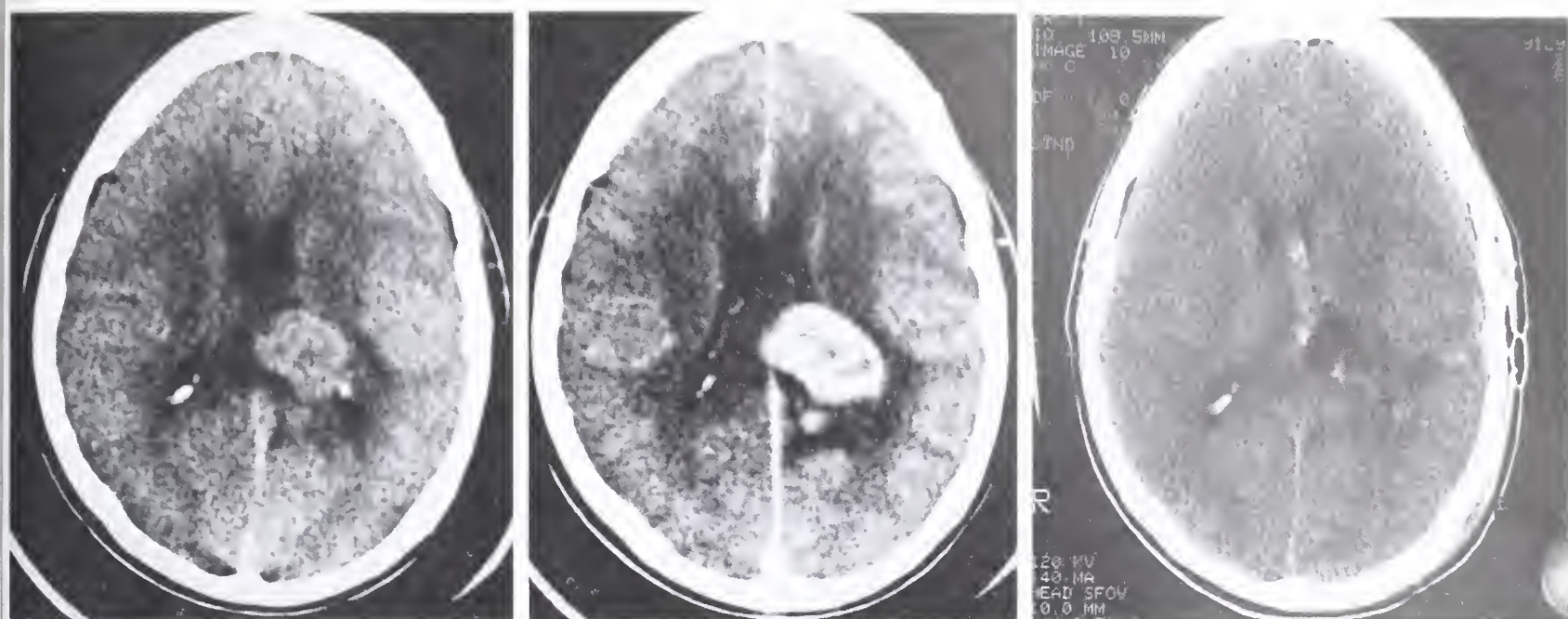
## Case Report

The patient, a 31-year-old right-handed Caucasian male electrician, worked at a gas pumping station for 12 years prior to his admission. It was discovered that a lubricating oil containing PCBs was used in air compressors at the site. Elevated PCB levels were also found in the soil and in fish in the nearby lake. The patient, the only worker at the station at the time, was selected to aid in the PCB investigation. Only at this point did he begin to wear protective gear consisting of a mask, rubber gloves, boots, and sealed clothing.

Five days before hospital admission the patient developed severe frontal headaches, which were worse at night but unaccompanied by nausea or vomiting. Preadmission evaluation included a CT scan of the head with and without contrast. This revealed a left paratrigonal mass lesion (Fig 1, A and B), resulting in his referral to the University of Louisville Neurosurgical Service for further evaluation.

Pertinent past medical history included a 15 pack-year history of smoking, peptic ulcer disease (treated successfully with cimetidine), kidney stones, and recent otitis media (treated successfully with antibiotics). A scalp lesion had been previously noted and excised. Pathology of this lesion revealed "sebaceous hyperplasia." His family history included an aunt with breast cancer. Physical examination revealed a healthy-appearing Caucasian male in no acute distress. Neurological examination was completely normal. General medical examination was negative for significant findings. Pertinent laboratory values included the following: albumin 4.3; total bilirubin 0.4; alkaline phosphatase 94; lactate dehydrogenase 165; serum glutamic oxaloacetic transaminase 37; serum glutamic pyruvic transaminase



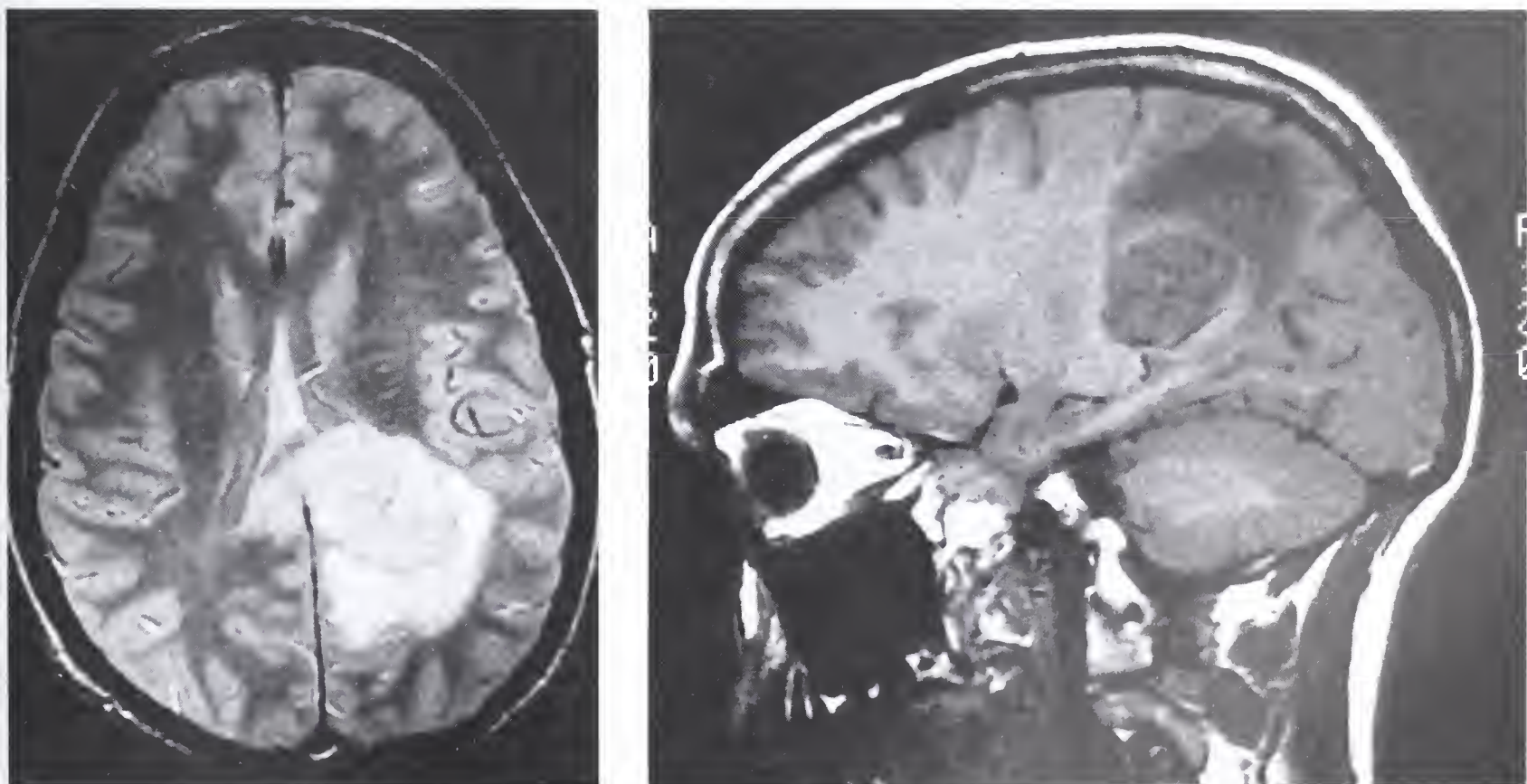


**Fig 1 — (A) Computerized axial tomography without and (B) contrast showing the patient's left paratrigonal mass lesion. (C) A postoperative scan showing tumor resection.**

101; cholesterol 223; triglycerides 410; hemoglobin 13.1; hematocrit 39.4; leukocyte count 19,700 (76S, 15B, 4L, 5M); platelets 220,000.

Preoperatively, an MRI scan was obtained in order to further define the anatomical boundaries of the lesion (Fig 2). An arteriogram was performed which revealed that the mass was avas-

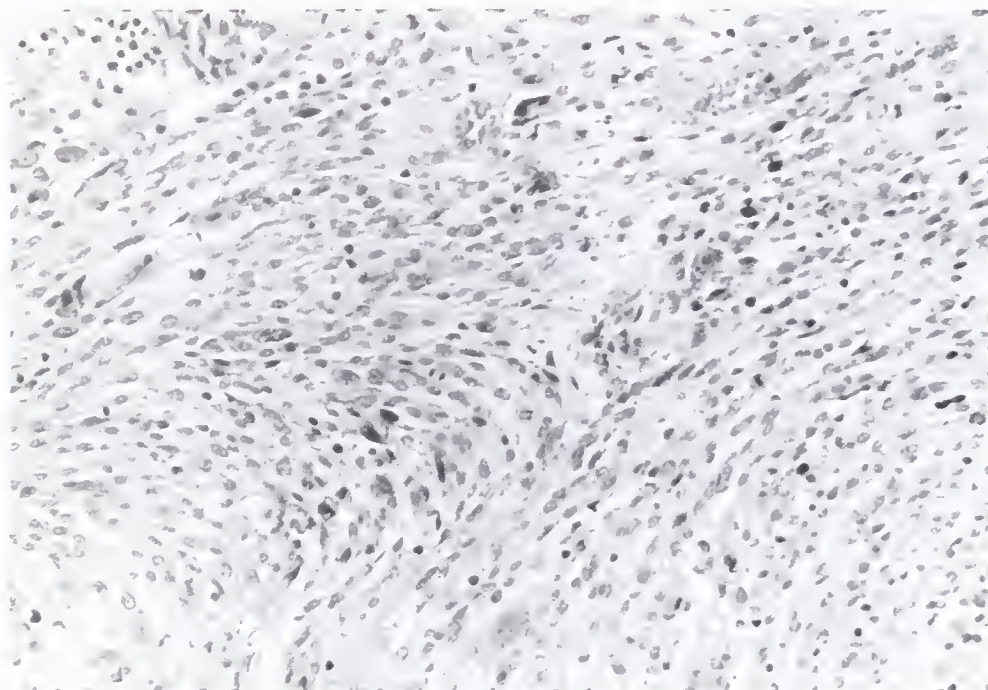
cular. The patient underwent craniotomy via a superior parieto-occipital approach, with the aid of cortical mapping and monitoring of the visual system by intraoperative visual evoked responses. A gross total resection was obtained (Fig 1C) and the patient recovered well in the postoperative period. A fat biopsy was later performed which



**Fig 2 — Magnetic resonance images of the mass lesion. (A) T2 weighted axial image showing the mass with surrounding edema. (B) T1 weighted sagittal image showing the mass compressing the corpus callosum and filling the trigone of the left lateral ventricle.**



## Glioblastoma Following PCB Exposure



**Fig 3 —** Light microscopy reveals some of the features of glioblastoma multiforme: necrosis, pseudopallisading, polymorphic cells with some showing mitosis, and endothelial proliferation.

revealed a PCB level of 410 parts per billion (normal is 0-12 parts per billion).<sup>17</sup> Pathology report revealed a diffusely infiltrating glioblastoma multiforme with focal monstro-cellular formation and fibrosarcomatous differentiation (Fig 3).

A 28-year-old co-worker of this patient also developed a malignant astrocytoma. He worked as a maintenance worker on the pipe systems during the summer months. During his period with the company he had frequent bouts of conjunctivitis and chloracne.

### Discussion

Signs of symptoms of heavy PCB exposure have been compiled<sup>8, 11, 15, 17, 24</sup> and are summarized in Table 2. Our patient showed several of these, namely mild anemia, leukocytosis, liver enzyme changes, hypertriglyceridemia with normal cholesterol, hypobilirubinemia and follicular hyperplasia. In the past, PCBs were widely used in hydraulic fluids and lubricants, plastics, surface coatings, installation, ink, adhesives, pesticide extenders, immersion oil for microscopes, and microencapsulation of dyes for carbonless duplicating paper. Worldwide production of PCBs had reached 570 million tons by 1972. The US stopped production of PCBs in 1977, but because

of their lack of biodegradability they remain widely distributed in the environment.<sup>9</sup> Many people are exposed to PCBs in their diet.<sup>24</sup> Two major PCB exposures occurred as a result of contamination of cooking oil,<sup>8</sup> thus documenting acute and chronic effects. PCBs are lipid soluble, making adipose tissue and brain sites of preferential deposition.<sup>18</sup> Interestingly, serum PCB levels do not correlate with levels in adipose tissue.<sup>5</sup>

There are 209 possible PCB configurations (congeners), 36 of which are possibly environmentally threatening.<sup>13</sup> Congeners sterically related to tetradibenzo-p-dioxin are directly toxic.<sup>8, 10, 11, 20</sup> Other congeners induced mixed function oxidases which convert nontoxic compounds (such as polynuclear aromatic hydrocarbons) to cytotoxic or mutagenic metabolites. Congeners that demonstrate 3-methycholanthrene-type and cytochrome P450 mixed function oxidation induction have the greatest toxic potential.<sup>13, 15</sup>

Some PCBs are also known carcinogens, having been shown to cause hepatic carcinogenesis in rats since the 1950s.<sup>6</sup> However, to date, the carcinogenic risk of PCBs to humans has been controversial.<sup>3, 4, 6, 17</sup> Some studies have linked exposure with an increased risk of carcinoma of the gastrointestinal tract and hematopoietic malignancy.<sup>1, 4</sup> The statistical significance of these findings have been in question.<sup>7, 17</sup> A recent study has shown that patients with PCB exposure can have increases in cellular oncogenes including *c-fos* and *H-ras*.<sup>2</sup>

The etiologic linking of a particular neoplastic lesion to a given chemical exposure can be problematic. Epidemiological studies are heavily relied upon, but these consist of individuals with different exposures, work histories, ages, and qualities of health care. The period between exposure and screening for cancer may not be long enough for disease to become apparent. The frequency of the neoplastic event may be low. Reportedly, the overall incidence and mortality of CNS tumors, particularly primary brain tumors, has been on the rise for white males since the 1940s.<sup>10</sup> This increase may indicate an environmental, possibly occupational, etiology.

Glioblastomas are relatively infrequent in young adults.<sup>23</sup> The occurrence of malignant astrocytomas in two young co-workers with PCB exposure could possibly have been a chance occurrence. The purpose of this report is not to definitively implicate PCBs as a causative agent in the pathogenesis of glioblastoma multiforme. Rather, it is to alert physicians to the possibility

of such a relationship. Exploring such relationships may lead to further insight into the environmental carcinogenesis of brain tumors and their possible prevention.

**ACKNOWLEDGEMENTS:** The authors wish to thank Ms Barbara Brown for assistance in preparation of the manuscript. The Brain Tumor Research Laboratory at the University of Louisville is supported in part by a generous gift from the Norton Kosair Children's Hospital Community Trust Fund.

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**Table 1. Chemicals Known to Produce Brain Tumors**

*Anthracene Compounds*  
Methylcholanthrene  
Debenzanthracene  
Benzpyrene

*N-Nitroso Compounds*  
Dimethylnitrosamine  
N-Nitrosopiperidine  
Dinitropiperazine  
Methylnitrosoareo  
Ethylnitrosoareo  
Acrylonitrile

*1,2-Diethylhydrazine*  
Azothione  
Azoxymethane  
Ethylene Oxide  
Propyleneimine  
Propane Sulfone

**Table 2. Effects of PCBs and Congeners on Humans**

Chlorocne  
Conjunctivitis  
Keratin cysts in hair follicles  
Hyperplasia of hair follicle epithelium  
Decreased number of red blood cells  
Lowered hemoglobin  
Hyperlipidemia  
Leukocytosis  
Hyperpigmentation of skin  
Liver enzyme changes, especially GTP  
Hypertriglyceridemia with normal cholesterol  
Adrenocortical and ovarian dysfunction  
Bronchitis  
Hypobilirubinemia  
Immunologic dysfunction especially T helper cells<sup>23</sup>  
Neurologic dysfunction  
Altered locomotor activity, convulsions, neuropathologic changes in spinal cord and limbic system, learning deficits<sup>21</sup>  
Reproductive Dysfunction  
Decreased spermatozoal motility  
Abortions  
Premature Delivery  
Toxemia of pregnancy  
Intrauterine changes  
Colo colored skin, low birth weight, conjunctivitis, facial edema, gingival hyperplasia, notal teeth, irregular calcification of the skull

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# The Management of Oral Mexiletine and Intravenous Lidocaine to Treat Chronic Painful Symmetrical Distal Diabetic Neuropathy

William E. Ackerman III, MD; George W. Colclough, MD;  
Mushtaque M. Juneja, MD; Kathleen Bellinger, RN

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*Intravenous local anesthetics administered to patients with chronic pain have been shown to provide significant levels of systemic analgesia. Furthermore, oral mexiletine which is similar in structure has been demonstrated to be efficacious in the treatment of diabetic neuropathy. It is recommended that this combined form of treatment be considered with those patients whose diabetic neuropathy is resistant to more conventional forms of treatment.*

## Introduction

Painful diabetic neuropathy can be resistant to various forms of treatment.<sup>1,2</sup> Imipramine and carbamazepine have been used with varying success.<sup>3,4</sup> However, intravenous lidocaine has been utilized with a statistically significant ( $p < 0.05$ ) decrease in pain when patients with painful diabetic neuropathy were treated in a double blinded cross over study.<sup>5</sup> But the duration of analgesia provided by intravenous lidocaine was inconsistent and ranged from 3 to 21 days.<sup>5</sup> Mexiletine has been recently reported to be efficacious in the treatment of chronic painful diabetic neuropathy.<sup>6</sup> Treatment of the pain of diabetic neuropathy in one patient using oral mexiletine was successful. A lidocaine infusion was administered prior to the administration of oral mexiletine. Oral mexiletine without a lidocaine infusion provided adequate but only short term analgesia. The case presentation follows.

## Case Report

A 58-year-old white female presented with a his-

tory of pain and decreased sensation in a stocking glove distribution in both lower extremities. The pain was reported to be worse at night. The patient had a 14-year history of insulin dependent diabetes mellitus. The loss of sensation and onset of pain in her lower extremities began approximately 3 years prior to her consultation. The patient also had a history of peripheral vascular disease. On physical examination, the patient was noted to be a well developed, well nourished, white female who appeared to be in moderate distress. Decreased sensation to pinprick and vibration were noted in both lower extremities beginning approximately 6 cm above each ankle. No motor nerve weakness in either lower extremity was noted on physical examination. The patient had been treated previously with phenytoin, imipramine, carbamazepine and a combination of amitriptylene and fluphenazine without significant pain relief. A diagnosis of symmetrical distal polyneuropathy was made. The patient's Verbal Assessment Pain Score prior to treatment was 8/10 (0 = no pain, 10 = excruciating pain). A lidocaine infusion of 1% was initiated intravenously at a rate of 3 mg/kg (200 mg) infused over 60 minutes while continually monitoring the patient's electrocardiogram. Following an infusion of approximately 65 mg of lidocaine, the patient's VAS score was 3/10. After the total dose, the VAS score was 0/10. The patient was discharged and returned within 3 days. Her VAS score returned to a pretreatment level 13 to 14 hours after her lidocaine treatment. A lidocaine infusion was reinitiated at the previous concentration and rate mentioned with prompt relief of the pain (VAS = 0). Oral mexiletine 150 mg PO bid was prescribed. The patient returned 7 days subsequent to the

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Ackerman).

initiation of mexiletine. The VAS was 0-1. The patient's mexiletine dose was decreased to 75 mg. She again returned at 48 hours, and complained of occasional breakthrough (2-6/10) pain. An ulcer was noted in the lateral aspect of her left foot. Her right leg was devoid of pain. The pain in her left foot was rated 5/10. She was referred to a general surgeon for debridement. Her mexiletine dose remained unchanged. Following surgical debridement of her left foot, the patient was seen after 3 weeks and reported no pain (0/10). Her mexiletine was discontinued, and within 36 hours the patient's VAS was 4/10. An intravenous infusion was reinitiated and her pain was relieved with 40 mg of intravenous lidocaine. Mexiletine was reinitiated as previously prescribed. The patient remained pain free, discontinued her mexiletine after 2 months, and did not return for further evaluations because she was "without pain." A telephone followup at 6 months revealed the patient continued to be without pain in her lower extremities.

## Discussion

Symptoms of painful symmetric distal polyneuropathy can include dull, burning, and/or excruciating pain. The pain may be worse at night. It is uncertain whether or not glucose control can affect the pain of diabetic neuropathy. However, hyperglycemia has been shown to decrease both a patient's pain threshold and tolerance to pain.<sup>7,8</sup>

The mechanism by which intravenous lidocaine decreases symptoms of painful diabetic neuropathy is unknown since the pharmacologic half-life of intravenous lidocaine is approximately 120 minutes.<sup>8</sup> Both central and peripheral mechanisms for the relief of pain following intravenous lidocaine infusion have been proposed.<sup>9,10,11</sup> However, a study by Deigard et al recently demonstrated no changes in neurologic tests, in blood pressure, or heart rate following either lidocaine or mexiletine treatment which suggested a central rather than a peripheral mode of action of either drug.<sup>6</sup>

It is not surprising that mexiletine is as efficacious as lidocaine in the treatment of painful diabetic neuropathy because mexiletine is structurally similar to lidocaine.<sup>11</sup>

Unlike tocanide, which is another oral derivative of lidocaine, mexiletine is safer in low doses and exhibits fewer side effects.<sup>6</sup> When plasma concentrations are greater than 2 mcg/ml, the following side effects can occur: nausea and/

or vomiting, tremor, dizziness, and blurred vision. The half-life is 8-10 hours. Mexiletine should not be used in patients with intracardiac conduction disease. In the treatment of chronic painful diabetic neuropathy, a loading is not indicated.<sup>6</sup> Side effects noted with mexiletine are dose dependent and can be minimized by using low (eg 175 mg bid) doses mexiletine.<sup>12</sup> The utilization of mexiletine appears to be promising for the treatment of the pain associated with painful diabetic neuropathy.

The use of mexiletine treatment is only symptomatic and does not alter the course of the disease. This case report supports the possible efficacy of lidocaine and oral mexiletine in the treatment of painful diabetic neuropathy. This form of therapy might be considered when more conventional means of therapy are not successful in the treatment of this painful syndrome.

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# Tuberculosis in the Intensive Care Unit: A Chemotherapeutic Controversy

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*A survey of 150 practicing pulmonary physicians was conducted to determine chemotherapy preferences for the treatment of the patient suffering respiratory insufficiency secondary to active nonmiliary tuberculosis. An equal sample was selected from both the private sector and academic medicine in order to determine if antituberculous agent selection differed between these two groups. The majority of the 109 physicians who responded to the questionnaire (64.2%) indicated that they would use isoniazid, rifampin, and a third agent. There was no statistical difference in the choice of ethambutol, pyrazinamide, or streptomycin as the third drug. There was no difference between university and community based physicians in the use of three drug combinations or in the selection of the specific third agent.*

*This study suggests that, although the majority of pulmonologists responding would treat the patient with respiratory insufficiency from tuberculosis with an aggressive three drug approach, there is no consensus as to which agent should be the third drug.*

## Introduction

The overall incidence of tuberculosis in the United States has not continued its rapid decline over the last 5 years, largely due to infection among Asian and Hispanic immigrants and immunocompromised populations.<sup>1</sup> The varied presentation of tuberculosis in these groups, including that of respiratory failure, has often led to misdiagnosis and delay in institution of appropriate therapy with a resultant high mortality.<sup>2</sup> Miliary tuberculosis has been well documented as a cause of respiratory failure,<sup>3-5</sup> while critical respiratory insufficiency from fibrocavitary tuberculosis is less well documented.<sup>6-8</sup>

Although the mortality of the patient with respiratory distress from nonmiliary tuberculosis in the intensive care unit is reported as 50% to 80%, there is no consensus as to the optimal antituberculous regimen for these seriously ill individuals.<sup>7,9</sup> This study was undertaken to determine the preferences of pulmonary physicians for specific antituberculous agents and their combinations for the treatment of respiratory insufficiency secondary to nonmiliary tuberculosis. Practice patterns of the sample cohort were compared to the current recommendations of the American Thoracic Society. The therapies chosen by pulmonologists in private practice were compared to those of university based physicians.

## Methods

A multiphysician survey was conducted to assess current treatment strategies for the patient with respiratory insufficiency secondary to tuberculosis. The population selected for survey consisted of 150 physicians who are members of the American College of Chest Physicians (ACCP) and who are currently practicing in the eastern or southeastern United States. All were eligible for or certified by the Pulmonary Subspecialty Board and considered experienced in the treatment of tuberculosis. The physicians were chosen at random from the ACCP directory to obtain an equal sampling of physicians in private practice and in university based medicine.

A simple questionnaire was developed using two inquiries regarding: (1) the number of antituberculous agents preferred for the treatment of patients in the intensive care unit with respiratory insufficiency secondary to tuberculosis; and (2) the specific agents used in such treatment. A list of eight FDA approved agents was provided. The possible selections included five first-line drugs (isoniazid, rifampin, ethambutol, pyrazinamide

and streptomycin) and three second-line drugs (capreomycin, cycloserine and kanamycin). Adequate space was provided for additional comments.

The questionnaires were printed on stamped self-addressed postcards and mailed to the selected physicians with a letter requesting their reply as a part of our study. All questionnaires were mailed on the same day. A 2-month period was arbitrarily chosen to await the replies. At the end of this time, the responses were analyzed.

Statistical evaluation of the results was performed utilizing the chi-square test and a p value of less than 0.05 was considered to be statistically significant.

## Results

Of the 150 physicians contacted, 109 (72.6%) completed and returned the questionnaire. Thirteen individuals provided additional comments and suggestions regarding treatment. Fifty-five physicians who replied (50.5%) were university affiliated and 54 (49.5%) working in community based practices responded.

All physicians used isoniazid and rifampin as the "backbone" of their therapeutic regimens. This two drug combination was used alone or in combination with ethambutol, streptomycin, and/or pyrazinamide. None of the physicians who replied utilized a second-line drug as part of their initial treatment regimen. The majority of the responding physicians (64.2%) elected to give their patients with tuberculosis induced respiratory insufficiency three drugs: isoniazid, rifampin, and either ethambutol, pyrazinamide or streptomycin. There was no statistically significant difference in this practice between university and community based pulmonologists ( $p = 0.94$ ). Twenty-seven physicians selected ethambutol as their third drug, 25 chose pyrazinamide, and 18 indicated that they would add streptomycin to the standard two drug regimen. Again, no statistical significance was found between which antituberculous agent was chosen to be the third medication in the combination by either the university or community based physicians ( $p = 0.24$ ) (Fig 1).

The remaining physicians chose either two drug therapy (17.4%) consisting of INH and rifampin or four drug therapy (16.5%). Only two individuals (1.8%) selected five drugs for this patient scenario. In no group did the difference between academic and community based physicians approach statistical significance (Fig 2).

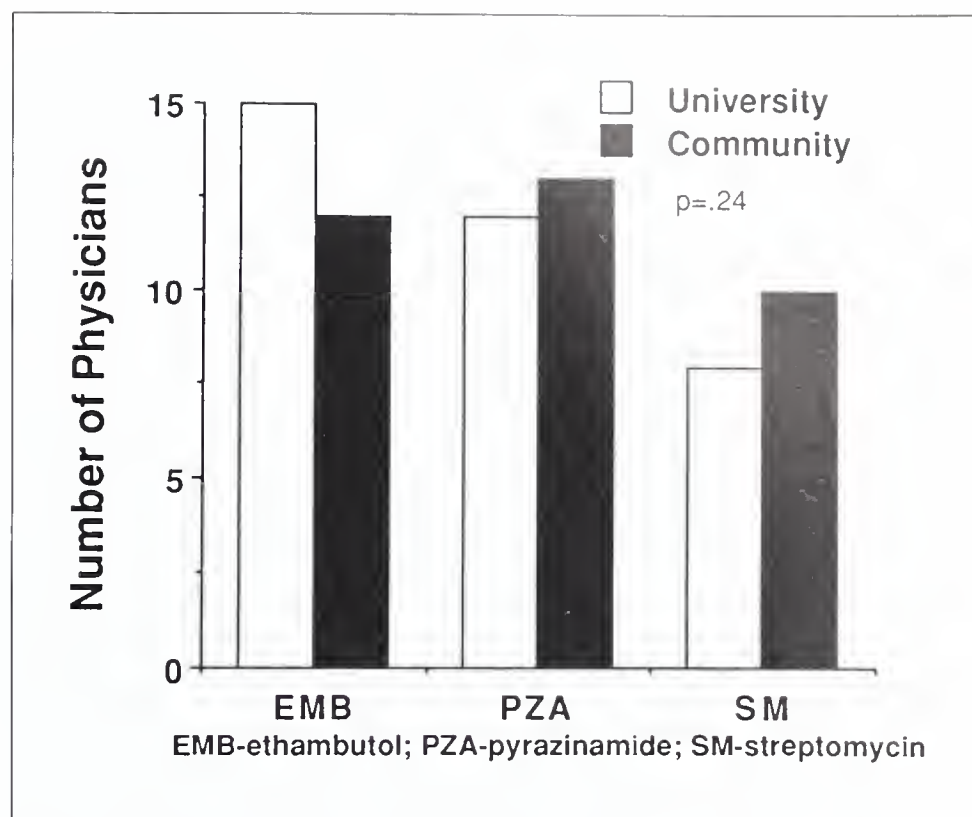


Fig 1 — Comparison of third antitubercular agent choice of university and community groups.

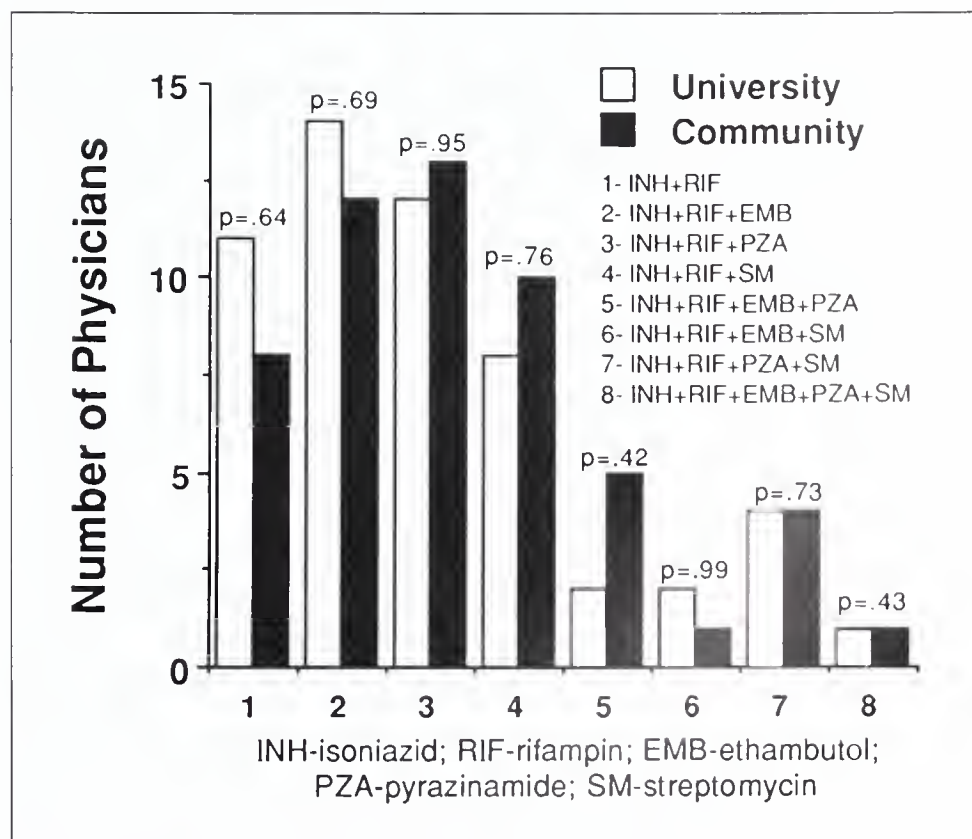


Fig 2 — Preferences of antitubercular drug regimens of university and community groups.



Six physicians (5.5%) volunteered that they would also use corticosteroids in the management of the patient. The respondents indicated that corticosteroids would be their "third" drug or an adjunct to three and four drug regimens respectively. For tabulating the results of the responses, corticosteroids were not classified as an antituberculous agent.

### Discussion

More than 25,000 cases of active tuberculosis were reported in 1986 by the Center for Disease Control, Atlanta.<sup>10</sup> Among those patients who required hospitalization, the incidence of respiratory insufficiency has been approximated at 3%.<sup>6, 11-13</sup> The precipitating factors for respiratory failure include debilitation, superimposed infection and multiorgan failure.<sup>7, 12-16</sup> Only rarely has tuberculosis without an associated trigger factor been reported as the sole cause for respiratory insufficiency.<sup>2, 6-8, 11, 12</sup> The influence of antituberculous chemotherapy on the morbidity and mortality observed in this subpopulation of tuberculosis patients is also poorly documented.

Since the advent of effective antitubercular chemotherapy, treatment of active tuberculosis has been based upon two principles. First, any treatment regimen should contain multiple drugs to which the organism is susceptible in order to decrease the risk of development of resistant microorganisms. Second, the agents must be given for a sufficient period of time to prevent relapse of the disease.<sup>17, 18</sup> In a joint statement by the American Thoracic Society (ATS) and the Center for Disease Control (CDC), it was determined that either 9 month therapy with isoniazid and rifampin or 6 month therapy with isoniazid and rifampin, with the addition of pyrazinamide in the first 2 months would be adequate therapy for all forms of pulmonary tuberculosis.<sup>18</sup>

The results of our survey indicate a lack of consensus regarding the appropriate treatment of the patient in the intensive care unit with respiratory insufficiency secondary to tuberculosis. The recommended standard two drug 9 month therapy was chosen by less than 20% of the respondents. The majority of the remaining physicians selected a three drug initial therapy, although the third drug chosen did not routinely follow the ATS/CDC recommendation of pyrazinamide. The reasons for departure from the ATS/CDC guidelines are probably multifactorial.

Patients admitted to the intensive care unit

with respiratory failure secondary to tuberculosis are as a group more critically ill than the majority of the population with newly diagnosed tuberculosis. Many have significant predisposing factors to the reactivation of their tuberculosis including renal failure, diabetes, alcoholism, and the Acquired Immunodeficiency Syndrome.<sup>9, 13</sup> These underlying debilitating diseases compromise immunocompetence and allow this subpopulation of tuberculosis patients to be overwhelmed by their infection. Also contributing to their overall mortality are the extent of the lesions, superimposed bacterial infection, barotrauma, malnutrition, disseminated intravascular coagulopathies and multiorgan failure.<sup>2, 4, 7, 9, 12-15, 19</sup> Likewise, although disputed by some, it would appear that the delay in diagnosis and initiation of appropriate chemotherapy increases the mortality of this otherwise treatable disease.<sup>2, 4, 11, 15</sup>

Should the entire population of newly diagnosed tuberculosis patients be treated in a similar fashion, or by virtue of the severity of their illness and the high mortality associated with it, do those in the critical care units with respiratory insufficiency warrant more aggressive chemotherapy? Because very little has been written in the medical literature about the treatment of tuberculosis in the critically ill patient, it is difficult to predict the influence of three drug therapy in the outcome of these patients. Although most papers are quick to discern the high mortality associated with this group, none delve into the role that multidrug chemotherapy may play in their survival. Some investigators have advocated treatment with a three or four drug combination, but the rationale and justification for this practice was not provided.<sup>11, 20</sup>

The majority of pulmonologists, either within the academic community or in private practice, who responded to our inquiries favored a three drug combination for the treatment of tubercular respiratory insufficiency. As no time frame was mentioned in the questionnaire, one may presume that three drugs were instituted on the basis of the severity of the patient's illness and not in adherence to the 6-month chemotherapy guidelines. The support of this presumption lies in the preponderance of physicians who selected as their third drug an agent other than pyrazinamide as recommended by the ATS protocol for 6-month therapy.

The intention of three drug combinations may be to provide more rapid eradication of the organisms in these severely ill patients. However, which additional agent would be most effective

is likely to be based on the coexisting underlying diseases of the patient.

Ethambutol is a bacteriostatic drug with the adverse effect of retrobulbar neuritis. Many would argue that the use of a bactericidal drug rather than a bacteriostatic drug may be indicated in these critically ill patients. Assessment of diminished visual acuity and altered red-green color discrimination secondary to the use of ethambutol is difficult in this population and lessens its attractiveness. The limited duration of these side effects would not preclude its use. It must be given orally, which necessitates an intact gastrointestinal tract for absorption, something not always present in the critically ill.

Streptomycin was not selected as frequently as pyrazinamide or ethambutol as the third drug. It is a bactericidal drug which, in the seriously ill patient, may be more efficacious in irradiation of the tubercular organisms. However, it too has potential side effects, the most common of which is irreversible eighth nerve damage, primarily to the vestibular component. As with ethambutol, testing of this nerve may be difficult in the bedridden patient. Its intramuscular route of administration is easily applicable to the majority of patients in the intensive care unit. As with any aminoglycoside, its dose must be modified in the presence of renal insufficiency. The ototoxicity and nephrotoxicity associated with this drug are dose related, and it is recommended not to exceed 120 grams.

The use of pyrazinamide is advocated by the ATS as the third drug in the proposed 6-month treatment regimen. It is a bactericidal agent whose efficacy has been supported by the evidence of low relapse rates when it is used in combination with isoniazid and rifampin.<sup>21</sup> Its hepatotoxic side effect may be additive to that of isoniazid and rifampin, also well known hepatotoxins. However, some investigators suggest that the risk of hepatotoxicity is no greater with these three drugs in combination than with either drug alone.<sup>22</sup>

The role of steroids in the treatment of severe pulmonary tuberculosis is controversial. In the absence of well controlled studies, their use in the treatment of central nervous system remains anecdotal, but in pericardial tuberculosis it has proven efficacious.<sup>23,24</sup> However, the role their anti-inflammatory effect may play in nonmiliary tubercular respiratory insufficiency has yet to be documented.

Several significant observations can be made from our survey. Among the pulmonologists sur-

veyed, there was no general consensus as to the most appropriate chemotherapy for tubercular respiratory insufficiency. The majority of responding physicians, whether in the community or university affiliated, were more likely to treat the patient with respiratory insufficiency in the critical care unit with three drugs. Although the ATS/CDC has recommended pyrazinamide as a third agent, there appears to be no agreement among pulmonary physicians as to which agent should be added as the third drug. Further prospective studies would be needed to validate that three drug therapy in the patient with respiratory failure secondary to tuberculosis is superior to the currently advocated two drug therapy of isoniazid and rifampin. Likewise, it would be important to document any observed advantages of the specific third drug chosen.

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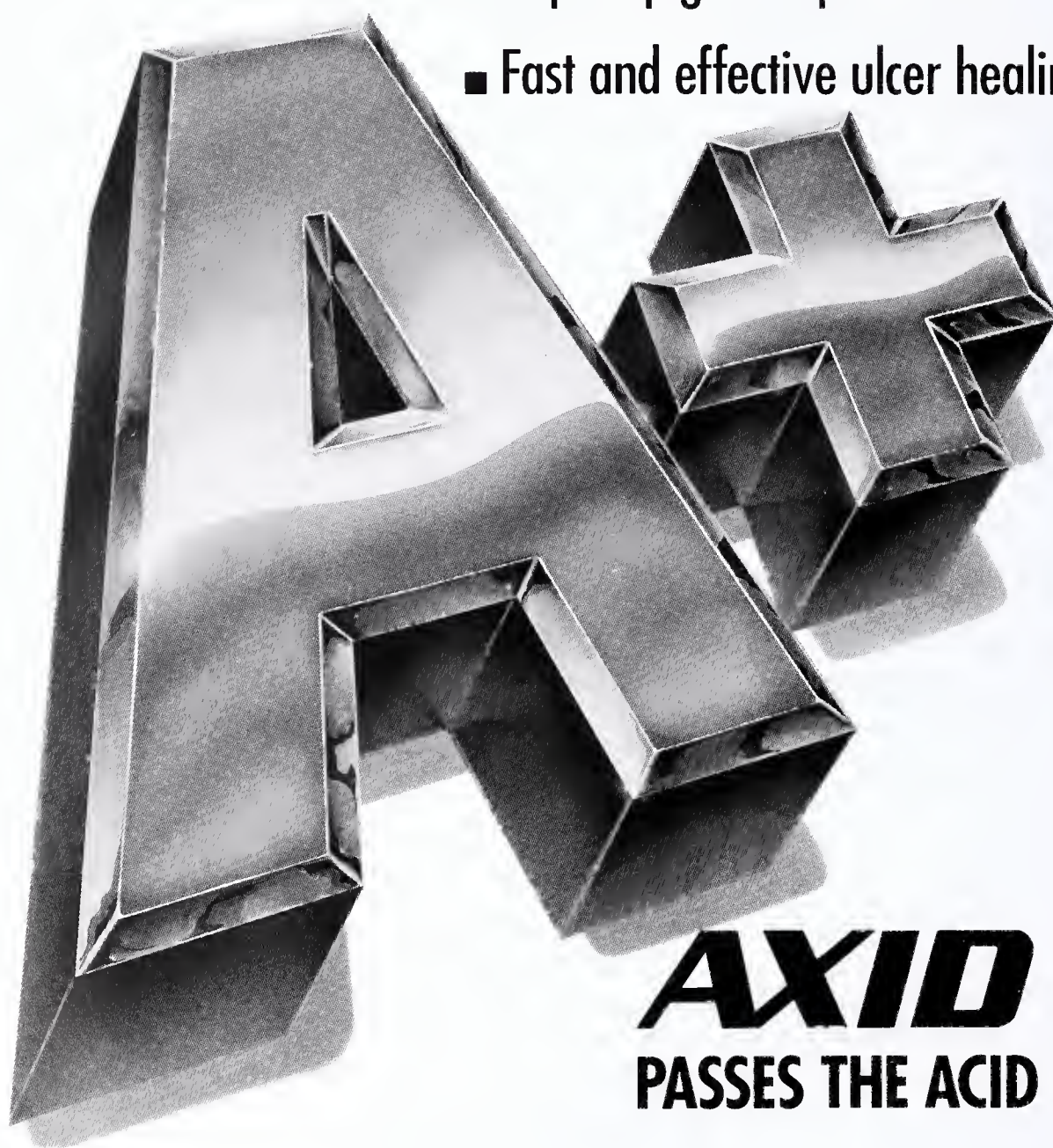


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2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

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*Drug Interactions*—No interactions have been observed with theophylline, chloridazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

*Carcinogenesis, Mutagenesis, Impairment of Fertility*—A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

*Pregnancy—Teratogenic Effects—Pregnancy Category C*—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect, but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

*Nursing Mothers*—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

*Pediatric Use*—Safety and effectiveness in children have not been established.

*Use in Elderly Patients*—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

**Adverse Reactions:** Clinical trials of varying durations included almost 5,000 patients. Among the more common adverse events in domestic placebo-controlled trials of over 1,900 nizatidine patients and over 1,300 on placebo, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common with nizatidine. It was not possible to determine whether a variety of less common events were due to the drug.

*Hepatic*—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

*Cardiovascular*—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

*CNS*—Rare cases of reversible mental confusion have been reported.

*Endocrine*—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to nizatidine. Impotence and decreased libido were reported with equal frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

*Hematologic*—Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H<sub>2</sub>-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

*Integumental*—Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

*Hypersensitivity*—As with other H<sub>2</sub>-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

*Other*—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.


**Overdosage:** Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis does not substantially increase clearance of nizatidine due to its large volume of distribution.

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# Life Begins at Forty

... weeks. There is great, noisy, and worldwide debate about the point at which a human life begins. If the disputants could reach agreement then their zeal and anger could be channelled in another political direction, peace and goodwill would settle on mankind.

Jerry Brown, a man of nature, a man of God, and a man of men, feels that birthdays are special:

**T**here is an instinctive feeling that my birthday is special. I make it commonplace with my mind but my gut tells me it is central in my life. The primordial scream was the most important moment in my life because then I began human life as I experience it with my eyes and ears. I began to be a part of the continuum of the universe and all of reality. I began to participate in the infinite.

**I** could say I began when my daddy's sperm penetrated my mommy's ovum. I could say I began when my daddy and mommy were born and on back through the countless ages and on back through the first moment of that first living entity that could move itself and on back through the evolution of the earth and the universe and on back to the big bang and on back to the cause of the big bang. All of the past is a part of me. The past is absorbed into the eternal now in me. As a seed slowly germinates, grows and blossoms, so I began to grow at birth. My potential is more than the potential of a seed in the ground. My potential is truly infinite at birth. My birthday is a new opportunity to begin anew to grow and blossom and to enhance the fullness of life and being.

**M**y birthday is the sacrament of life. The singing of the happy birthday song, the lighting the candles, the eating of cake and ice cream and the whole celebration are the sacramental rituals of life — the beginning of human life — an expression of all the beauty and happiness of life.

— JERRY BROWN

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A. Evan Overstreet, MD  
Editor



# Kentucky Medical Association

is pleased to cosponsor six

## AMA WORKSHOPS ON RBRVS AND MEDICARE PAYMENT REFORM

**TUESDAY, NOVEMBER 5, 1991**

cosponsored by Northern KY Med Society

**Drawbridge Inn - Ft. Mitchell**

**9:00-11:30 am**

**1:00-3:30 pm**

**WEDNESDAY, NOVEMBER 6, 1991**

cosponsored by Fayette County Med Society

**French Quarters Suites - Lexington**

**9:00-11:30 am**

**1:00-3:30 pm**

**THURSDAY, NOVEMBER 7, 1991**

**Greenwood Executive Inn**

**Bowling Green - 9:00-11:30 am**

**and**

**Owensboro Country Club**

**6:00-8:30 pm**

### REGISTRATION FORM

Please indicate which workshop you plan to attend.

**November 5 - Ft. Mitchell**

☐ 9:00 - 11:30 am ☐ 1:00 - 3:30 pm

**November 6 - Lexington**

☐ 9:00 - 11:30 am ☐ 1:00 - 3:30 pm

**November 7**

☐ **Bowling Green** ☐ **Owensboro**  
9:00-11:30 am CST 6:00-8:30 pm CST

#### COURSE TUITION

Per enrollee

KMA Member Physician and/or office staff - \$ 75

Nonmembers and/or office staff - \$125

Enclosed is my check for \$\_\_\_\_\_ (\$75 or \$125 per enrollee)

Enrollee Name \_\_\_\_\_

Mail check (made payable to Kentucky Medical Association) and form to: RBRVS Workshop, KMA, 301 N Hurstbourne Pky, Suite 200, Louisville, KY 40222-8512. Telephone contact: Diane Maxey at KMA (502) 426-6200.

Practice Name \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Please make a copy of the form for additional enrollees.

Phone ( ) \_\_\_\_\_

## Leadership Training Offered by AMA Auxiliary

It's been called the best leadership training offered by the AMA Auxiliary. It includes sessions on leadership, current health concerns, and socioeconomic issues. It is experienced by several hundred state and county auxiliary leaders every year. It is the AMA Auxiliary Leadership Confluence, held twice each year to provide in-depth training for medical auxiliary leaders.

Two Confluences are planned for the 1991-92 Auxiliary year. The first was held October 6-8 at the Drake Hotel in Chicago, Illinois. The national auxiliary paid 75% of the travel expenses for the 200 county presidents-elect who were chosen by their state presidents to attend. The second Confluence for this auxiliary year will be held February 2-4, 1992, also at the Drake Hotel in Chicago.

The number of county presidents-elect each state is allotted is based on that state's AMA Auxiliary membership for the previous year. Kentucky is allowed to send six county presidents-elect each year. Three attended this month and three more will attend in February. Attending this month, along with our state president and president-elect, were the following county presidents-elect:

From Daviess County —

Vicki Hast (Mrs John)

From Fayette County —

Theresa Back (Mrs W. Douglas)

From Jefferson County —

Rose Gardner (Mrs Hoyt D.)

Confluence is a rare opportunity to learn organizational and management skills and to obtain specific program suggestions that are

appropriate for either state or county auxiliaries. Information available includes breakout sessions on political action strategy, AMA-ERF fundraising, parliamentary procedure, time management, speech training, environmental concerns, teen sexuality, family violence, and much more.

The AMA Auxiliary Leadership Confluence is only one of many ways in which we benefit from the federation of county, state, and national medical auxiliaries. Confluence provides us with the opportunity to learn from people who are at the top of their professions, to set goals for our local auxiliaries, and establish guidelines for meeting those goals.

If your spouse is not currently a member of the Auxiliary to the Kentucky Medical Association, perhaps you would like to give him/her a gift membership. We hope that your spouse will become an active participant in auxiliary activities, but if not, being a dues paying supporter of auxiliary programs is also important. For information on AKMA membership contact:

Jean Wayne, Executive Secretary  
AKMA Office  
Hurstbourne Forum Office Park I  
301 N Hurstbourne Parkway, Suite 200  
Louisville, KY 40222-8612  
502/426-6200

*Beryl Dadds*

**AKMA President-Elect**



***“Confluence provides us with the opportunity to learn from people who are at the top of their professions, to set goals for our local auxiliaries, and establish guidelines for meeting those goals.”***



# S. Randolph Scheen, MD KMA's President 1991-92



In a life-threatening situation — sitting in a foxhole on Iwo Jima during World War II — Randy Scheen made a decision. If he survived, he would pursue a career in a life-strengthening profession — as a physician.

"I landed with the 4th Marine Division on D-Day. We had a lot of work to do on the beach during the day, but many nights while sitting in our foxholes, we would talk about what we were going to do when we got 'back home.' I was paired with an older Seabee from Philadelphia. I remember he was Italian but I can't recall his name. He philosophized about life and how he wished he had been a doctor. Through our discussions, my desire to become a physician surfaced."

Later, this young Seabee wrote his mother in Louisville to send information on the University of Louisville Medical School. In 1946, following three years of military service, he enrolled in U of L's premed program, earning his undergraduate degree in 1949. "I was accepted to medical school in 1949. Actually, that year there were some 4,000 applications for 90 places, and I was concerned I would not be accepted, so I also applied to Michigan State University School of Wildlife Conservation, with plans to be a forest ranger or something like that." Dr Scheen displayed his quick sense of humor. "If I hadn't been accepted to medical school, I might be chasing bears in one of the national parks."

"Chasing bears" is a world apart from a Dermatology Fellowship at the prestigious Mayo Clinic and the events that ensued in Dr Scheen's pursuit of his chosen specialty. He obviously enjoys reminiscing about this period in his life and three people who had great influence on

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***"I think that anyone who has read our KMA brochures on what KMA has done for its members would appreciate the efforts of organized medicine."***

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his career. "I made rounds with the late Dr Morris Fleigleman, one of the prominent dermatologists in Louisville. His knowledge in handling patients impressed me, and there was something about seeing the diseases that were being treated that intrigued me. Fleigleman stimulated my interest in dermatology, so after finishing internship I entered a dermatology residency at Cincinnati General Hospital under Dr Leon Goldman, for whom I had the highest regard.

"In September 1956, while attending a meeting at the Mayo Clinic, I became acquainted with Dr Louis Brunsting, a world renowned dermatologist and Mayo's professor of dermatology. Dr Brunsting and I spent time in conversation at a couple of receptions, and much to my amazement, he asked if I would be interested in joining the Mayo Clinic residency program if there was an opening. Of course, I was tremendously interested — it was a wonderful opportunity, but Dr Goldman would have to agree. A couple of months later Dr Goldman advised that Dr Brunsting recommended me to serve a residency at the Mayo Clinic and gave his blessing to leave Cincinnati

General. I was so exhilarated, I could have taken wings and flown! It was a chance of a lifetime — not only to study at Mayo Clinic, but to study under an internationally known dermatologist. Betty, my wife, was in total agreement, so in January of 1957 we moved to Rochester, a wonderful city, where I studied at Mayo Clinic for three years, returning to Louisville in late 1959. Through the affiliation of Mayo Clinic and the University of Minnesota, I earned a Masters Degree in Dermatology from the University of Minnesota."

#### **Involvement in Organized Medicine**

The names of S. Randolph Scheen, MD, and the Kentucky Medical Association have been synonymous for 24 years. Willingness to serve has involved Dr Scheen in extensive areas of KMA and organized medicine for many years. He recognizes that physicians have compelling reasons to become advocates of organized medicine. Scheen notes in today's climate you can't practice medicine in a vacuum; you can't just see patients; you have to be involved in the mechanics of organized medicine to survive. Simply stated, Dr Scheen provides a constant testimony that the rewards of service are tremendous.

"I have a very strong feeling about organized medicine, and with my background and tenure I can speak to the many accomplishments during my 24 years of involvement. It would take much too long to enumerate them, but let me assure you that we would not be able to mount a strong effort to combat many of the governmental intrusions into medical care. I think that anyone who has read our KMA brochures on what KMA has done for its members would appreciate the efforts of organized medicine. Also, I can tell you that it



has brought me a great deal of pleasure, given me an opportunity to meet many of my colleagues out in the state and in surrounding states, and has certainly been a very rewarding experience."

Dr Scheen downplays his initiation as a forceful player in the leadership of KMA. "I really had only been involved locally in the Jefferson County Medical Society when Henry Asman approached me one day and asked if I would fill in his unexpired term as secretary if he took over the Presidency of KMA. I said, 'Well, Henry, how long would this last?' He said, 'About a year and a half,' so I said, 'Well fine, I believe I could do that for a year and a half.'" Dr Scheen smiled warmly and said, "As you know, it turned out to be 24 years."

### Preventive Health Care

Physicians today have more knowledge, procedures, and treatments available enabling them to help people survive. To enhance these abilities, KMA's theme for this year, "Prevention: Rx for Health Care in the 90s," embraces two of medicine's greatest resources — prevention and education. Dr Scheen's comments on this are practical. "We all recognize that prevention in health care is much less costly and involves much less pain and suffering for patients than diagnosis and treatment. The control of communicable diseases such as AIDS and hepatitis B should certainly be high priorities, as well as programs to prevent breast cancer and heart disease."

"AIDS continues as a major health care problem. A great deal of research is being done, and I think there are a number of new experiments on the horizon which may produce a vaccine or some form of therapy to increase the immune system in these compromised patients. AIDS is a primary example of a disease where prevention and

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***"Membership plays an essential role in the future of medicine. To accurately represent their opinions, every physician must participate at the county level and state level. I would like to see more involvement by rural physicians. I'm hoping we can encourage many of these very bright and articulate people to participate. Their voices should be heard, and I look forward to hearing from them."***

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education are crucial in preventing the spread of the infection." Dr Scheen continued, "Sometimes we get so involved in socio-economic issues that we lose some sight of the fact that we are primarily physicians and that prevention, education, diagnosis, and treatment are what we are trained to do."

### The Changing Face of Medicine

Practicing dermatology for over 32 years has given Dr Scheen a valuable perspective on the changes in medicine. He began practice in the days when an older system of values prevailed and when money was very scarce. "I began practice down in Cloverport, Kentucky, prior to Medicare and Medicaid. We were often paid with plum preserves and tomatoes when they were in season. Many of our bills weren't paid until the tobacco was sold, because

everyone paid cash in those days. Certainly, we had a lot less paperwork and very little government intervention. I think my liability insurance at the time was \$25 a quarter, or approximately \$100 a year, and I carried a maximum coverage of 5 and 15 thousand." Dr Scheen lamented, "Yes, there's been a great deal of change."

He went on to briefly review some of the major issues. "In the existing system, the people paying the bills are not the patients. Businesses who carry the insurance contracts and government pay the vast portion of our fees."

Dr Scheen was extensively involved in the founding of KMIC and has been on their Board for 14 years. He has far-reaching knowledge in this area. "We would certainly like to see the liability problem easing, but this tends to be cyclical in nature where we go several years with reductions in claims followed by years with dramatic increases. There has been a slight decline in claims recently, but we can expect an upswing in the next few years."

Dr Scheen worries about the present climate of medicine where information is readily available to the public. "Technology has played an important role in the escalation of health care costs. We need to constantly be aware of how effective some technology is in terms of providing better medical care for our patients and under what conditions and situations we use these technologies. Patients are well educated concerning medical procedures and treatment regimen, and many insist on the latest technology — whether or not it is specifically applicable to their problem."

Beginning in the 1960s, the federal government, congress, and every president since then, has promised American people that when they get old, government will take care of their health needs. This has



**KMA President Scheen is pictured with family members in attendance at his Inauguration — (L to R) son Patrick; Dr Scheen and wife Betty; son Dr Randy Scheen, III, and his wife Mary; daughter Ellen King and her husband Pat Corbett.**

proven to be a hollow promise, one of great concern to Dr Scheen. "As the population grows older and people live longer, health care costs are certainly going to rise.

Approximately 11% of the GNP is at present going into health care. As of last year, we spent \$550 billion on health care — more than any other country in the world. To quote a recent article, 'If current trends continue, health care costs will double by 1995 and triple by the year 2000, to \$1.5 trillion, or 15% of the GNP.' The author of this article

predicted that by the year 2005 the federal budget for Medicare alone will exceed that for either Social Security or the Department of Defense. And of course, not only is there concern for the aged, there is the very real problem of the 35-40 million uninsured and indigent."

KMA urges key players in healthcare — the physicians, the patients, the business community, state and federal governments, the pharmaceutical industry, the insurance companies, and the hospitals — to accept responsibility and do their part to assure that access to quality medical care is preserved for Kentucky citizens. Dr Scheen is proud of KMA for its efforts. "One thing our Association can point to with pride is our Kentucky Physicians Care Program which has been in place for about 6 years and has been a model program for caring for uninsured or inadequately insured patients. KMA has received national recognition for this program, and we are very proud of the fact that half of our members participate. We certainly applaud Russell Travis of Lexington

who has been the real driving force in keeping this program going and expanding the program by getting Pfizer to provide free pharmaceuticals for KPC patients.

"The 1990s will continue to hold many challenges for medicine," Dr Scheen emphasizes as he looks to the future. "There will be ongoing changes in our nation's medical system, changes in medical technology, and changes in medical treatments. During my year as president of KMA, I intend to inform the membership about these trends, and do my best to preserve and protect the quality of medicine practiced in Kentucky."

#### **KMA Membership—A Priority**

It's a simple fact — the more members KMA has, the more resources it will have to do what the members expect it to do. And that is, keep KMA the powerful influence it is, and has been, and will continue to be. Dr Scheen is confident in the leadership of KMA and AMA. When asked about KMA's future, he

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***"The increased role of women in medicine is good; they have a great deal to offer. I encourage their membership and involvement. We need their leadership in KMA."***

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reiterated his goals and expressed the need for a strong unified group of physicians.

"Organized medicine represents the interest of all Kentucky physicians," reminds Dr Scheen. "Membership plays an essential role in the future of medicine. To accurately represent their opinions, every physician must participate at the county level and state level. I would like to see more involvement by rural physicians. I'm hoping we can encourage many of these very bright and articulate people to participate. Their voices should be heard, and I look forward to hearing from them."

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***"Sometimes we get so involved in socio-economic issues that we lose some sight of the fact that we are primarily physicians and that prevention, education, diagnosis, and treatment are what we are trained to do."***

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A major goal of Dr Scheen's is to accommodate the profession's changing demographics by encouraging the input and participation of women. "Over the past 10 years the number of women applicants has increased greatly. Approximately 35% to 40% of our medical school class is female. When I was in medical school in 1949, we had six women in our class, so you can see there has been a dramatic change, and I think this is excellent. The increased role of women in medicine is good; they have a great deal to offer. I encourage their membership and involvement. We

need their leadership in KMA."

Although KMA currently represents approximately 5,200 physician members throughout the state, there are still many physicians in Kentucky who are not members. "We need all physicians as members. Many spokespersons are needed for the profession. We'd do a better job of representation if we were united and able to speak for 100% of Kentucky physicians."

Dr Scheen manifests an integrity, an effectiveness, an insight which influences others to join his efforts, which is what he will be doing as he spreads his message throughout the Commonwealth during his busy year as KMA President. "I plan to visit all of the trustee districts, all of the associational meetings of surrounding states, as well as national meetings in order to better communicate at all levels our efforts to care not only for patients but our physicians as well, and to encourage more involvement in organized medicine."

During his 24 years of service, Dr Scheen has seen many changes in KMA. A recent tangible change, though difficult to deal with from a sentimental perspective, has received his enthusiastic approval. "The recent sale of our KMA building on Ephraim McDowell Drive and the move to the Forum Office Center on Hurstbourne Parkway was a positive step. The Board of Trustees, Executive Committee, and the members involved on the committee for investigating this change did an excellent job, and I believe that the KMA membership agrees. It is certainly going to give us a more functional and updated office so that the operation can be even more efficient than it has been in the past."

#### **A Legislative Year**

"I've been involved in several Kentucky General Assembly sessions," says this seasoned veteran with a grin. "In the area of health care, I feel the 1992 session will most likely be

directed toward problems we really can't solve. Most of our problems revolve around the cost of health care, whether we like it or not. Unfortunately, this is an issue that state government has a difficult time addressing, since most funds are controlled by federal government. We will, however, work with the Legislature in an effort to resolve the problem. We certainly expect punitive legislation directed toward physicians such as mandated participation in government programs, allowing non-physician practitioners to prescribe and diagnose, and more government intervention into how we practice."

But an optimistic Dr Scheen notes that there is still hope for organized medicine to flourish despite forces opposing medicine — and that is through a united front. "Physicians are doing well in the political arena. This has never been more dramatically displayed by AMA's leadership and physician participation on the grass roots level than in the recent controversy over the Resource Based Relative Value Scale and the 16% discount they were trying to cram down physicians' throats. When we asked members to write their congressmen, they responded en masse. But we can't stop now.

"Another way of supporting organized medicine is to belong to KEMPAC. We've got to start supporting and electing people who share our philosophy. KEMPAC helps us do that."

#### **The Profession**

Dr Scheen cares deeply about his patients and his profession. His voice is even, pleasant, and mainly on low volume, but *intense* as he discusses the perpetuation of the profession. "I tell young people thinking of pursuing a medical career *to do it!* It bothers me to hear physicians say they would never tell their son or daughter to go into medicine. I still feel that medicine is a grand profession, probably the grandest of all

professions. It requires a lot of hard work and has its disappointments, but the sense of fulfillment when you bring a patient through a serious illness is unmatched in any profession.

"Dr Nunnelley's theme for last year, 'Pride in Medicine,' was an appropriate one. We need to restore pride in our profession, tell people how much we love our profession, and encourage young people to choose medicine as a career." The betterment of medicine has occupied much of Dr Scheen's time, and he is a strong advocate of practicing professionalism at all times. "There's more to pride in medicine than just the mental side. There's also the physical side. Someone once said, 'A physician should walk like a doctor, talk like a doctor, dress like a doctor, and act like a doctor.' I think these are good words for all of us to remember."

### A Personal Glimpse

Randy Scheen is warm and friendly. His manner is confident and easy. He has a quick, contagious smile which lights his face as he speaks proudly of his family. "Betty and I married in 1949 during my first year of medical school. She supported me by teaching first grade while I was in medical school and at the Mayo Clinic. Betty is a Past President of the Jefferson County Medical Society and is currently involved in volunteer work and fund raising for the John H. Morgan Center for the homeless. We have five children and seven grandchildren.

"The eldest, Randy, also a dermatologist who trained at Mayo Clinic 20 years after I did, met his lovely wife, Mary, while working at Mayo. They have two children. Our second child, Ann Mary, graduated from Vanderbilt as an art history major. Her husband, urologist Thomas DeMarco, completed his undergraduate work at Dartmouth and graduated from medical school in the

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***"I tell young people thinking of pursuing a medical career to do it! . . . I still feel that medicine is a grand profession, probably the grandest of all professions."***

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same class as Randy. Ann and Tom live in Salisbury, Maryland and have two children. Our middle child is Kevin Joseph, a presiding judge for the Harness Tracks of America, who currently serves at Pompano Harness Track in Florida. Our fourth child, Ellen King, an accountant, received her degree from the University of Kentucky. She's married to Pat Corbett, Vice President of Sam Meyers Formal Wear in Louisville. They have three children. Our fifth child, Patrick, also a graduate of UK, is in telemarketing management at Humana.

"They're all wonderful children," remarks Dr Scheen. "I've always been very proud of them. And certainly, as all grandfathers are, I'm much in love with all my grandchildren."

When asked about his "leisure time," Dr Scheen chuckled. "I really don't have much, but a great deal of what I have is spent playing golf — probably too much since it doesn't seem to improve my game. I also enjoy fishing with my retired, fishing guide cousin in Lake Okeechobee, Florida. Betty and I go to the theatre quite often, and enjoy listening to opera. I play a little gin rummy, but not very well. And of course, we spend a great deal of time with our grandchildren and have been known to do a little babysitting."

In addition to the personal time Dr Scheen devotes to KMA, he frequently represents the profession

on the Milton Metz WHAS radio show in Louisville and various local TV programs. "I'm a member of the American Academy of Dermatology and the Kentucky Dermatologic Society, but with my KMA involvement, I haven't had much time for other societies. I've served on the advisory council to the Kentucky Board of Nursing for approximately 15 years. This is a position appointed by the Governor. In the past, I have taught in the dermatology clinics at the University of Kentucky and University of Louisville medical schools, as well as giving lectures."

### The Presidency

"I would be very proud of my presidency if we had a substantial increase in KMA membership during my term in office; if our preventive medicine program can produce some new thrust in promoting education and new ideas in the field of preventive medicine; and if we are able to accomplish some of our goals in the state legislature that would be beneficial to the citizens of Kentucky."

When asked how he would like to be remembered, Dr Scheen responded, "It is my wish to be remembered as one who enjoyed his work and efforts through organized medicine to protect and guard the integrity and ethics of the medical profession. KMA was formed to ensure quality medical care for the people of the Commonwealth. To follow in the footsteps of great KMA Presidents is a very difficult thing to do . . . but with the help of many of my physician friends — I will do my best."

"Finally, my good friend, the late Dr Fielding Rubel, when asked how he would like to be remembered, simply said one word, 'Nicely.' I'm sure my friend Fielding wouldn't mind my stealing a quote from him. 'That's a good way to be remembered — nicely.'"

— Sue Tharp  
Managing Editor





**KMA Secretary-Treasurer William P. Vonderhaar, MD, signed the purchase agreement as Executive Vice President Robert G. Cox looked on.**



**Bob Cox had mixed emotions as he watched his KMA home of 30 years being emptied into moving vans.**

# KMA — On the Move

In 1961 the Kentucky Medical Association erected its headquarters building on Ephraim McDowell Drive. Physicians of Kentucky were served from that location for 31 years. Since that time, the KMA's membership and services to its members has grown at a rapid pace. The KMA House of Delegates directed that various additional subsidiaries be formed to serve physicians, highlighted by the formation of Kentucky Medical Insurance Company in 1978. KMIC, in just a few short years, became the largest insurer of physicians in Kentucky. The old headquarters building was expanded on two separate occasions; however, the continued growth of KMIC and the lack of available land adjoining the old building restricted parking areas, thus preventing any further growth.

KMA and KMIC have now moved to Forum Office Park on Hurstbourne Lane. The Kentucky Medical Association has signed a five-year lease, anticipating either the purchase or building of a new location at the end of that time. The Association, while regretting the necessity to move to a new location, is extremely pleased to find a nonprofit health organization, Hospice of Louisville, to carry on the traditions and services of health care at that historic location. *KMA*





*KMA's home for 31 years*

*KMA's new home —  
Hurstbourne Forum  
Office Park*



*The Committee for Community and Rural Health held one of the first meetings in the new office location. Ardis D. Hoven, MD, at the head of the table, chairs the committee.*



# Board of Trustees August Meeting

**T**he KMA Board of Trustees held its fifth meeting of the Association year on August 7-8, 1991, at the Oxmoor Steeplechase Clubhouse. Reports were given by the President; Secretary-Treasurer; Commissioner for Health Services; Dean, U of L School of Medicine; Medical Director of the Medicare Part B Program; and a member of the Board of Medical Licensure. The new President and CEO of the Kentucky Medical Insurance Company, Steven L. Salman, was introduced, and he presented a brief report.

President Preston P. Nunnelley, MD, reported that the sale of the KMA Headquarters Building to Hospice of Louisville, Inc, should be completed in early September, and he noted that space had been leased for the KMA staff in the Forum Office Park on North Hurstbourne Lane for a 5-year



*President Preston P. Nunnelley, MD, Lexington (L), studied the agenda with President-Elect S. Randolph Scheen, MD, Louisville (center), and Vice President William B. Monnig, MD, Edgewood.*



*The Board of Trustees held its first meeting at the Oxmoor Steeplechase Clubhouse location.*



period. Dr Nunnelley presented a bound set of Journals to Nelson B. Rue, MD, Immediate Past President, which were published during his term as President.

The Senior Delegate to AMA highlighted actions taken at the AMA Annual Meeting in June, which included lengthy discussions on HIV testing and Medicare Physician Payment Reform. It was noted that KMA had encouraged its membership to write to the Kentucky Congressional Delegation regarding concerns relating to the RBRVS issue.

It was reported that the PLI campaign is in full swing, and that the Gallup Poll of 1,000 consumers and 150 legislators and business people, which is being conducted for KHA and KMA, is expected to be ready by October. The intent of the poll is to determine attitudes regarding health care costs, access to care, and concerns with the malpractice situation.

The Board reappointed all current Journal Editors for additional two-year terms; joined with several other groups in endorsing the posthumous nomination of Nicholas J. Pisacano,

MD, for the AMA Benjamin Rush Award; and submitted the name of W. Stephen Aaron, MD, Louisville, for nomination to the HCFA Practicing Physicians Advisory Council. It was also agreed to invite Alternate Trustees to attend the Sunday, September 29, meeting of the Board of Trustees to be held during the Annual Meeting.

The Board authorized a \$10 voluntary assessment for the Legal Trust Fund to be included with the 1992 dues billing.

The ad hoc committee reports of the Board were finalized, and a review was made of each final report submitted by the KMA committees. A listing of actions taken to implement the directives of the 1990 House of Delegates was distributed, and it was noted that the same information would be sent to every Delegate as an addendum to the Board Chairman's Report to the 1991 House of Delegates. The Board also approved several Resolutions for introduction into the House.

The next meeting of the Board was scheduled for Sunday, September 29, 1991. *KMA*



*Larry J. Wilson, MD, Alternate Delegate from Jefferson County (L), and Russell L. Travis, MD, Lexington, Chairman, Kentucky Physicians Care Operating Committee.*



*Immediate Past President Nelson B. Rue, MD, Bowling Green (L), accepted a bound volume of Journals from President Nunnelley.*



*Among those seated at the head table were (L to R) KMA Executive Vice President Robert G. Cox; Board Chairman Cecil D. Martin, MD; President Nunnelley and President-Elect Scheen.*



*AMA Alternate Delegate Ardis D. Hoven, MD, Lexington, was seated across from AMA Delegates Harold L. Bushey, MD, Barbourville, and Wally O. Montgomery, MD, Paducah.*



# Physician Recognition Award Recipients

**L**isted below are KMA member physicians in Kentucky who have earned the AMA's Physician's Recognition Award (PRA) from July 1990 through June 1991.

The Award was established by the AMA House of Delegates of the American Medical Association in 1968 "to encourage physician participation in continuing medical education and to recognize physicians who have voluntarily completed programs of continuing medical education." A minimum of 150 credit hours of CME must be earned over a consecutive 3-year period to qualify for the Award. Of these 150 hours, at least 60 must be in AMA/PRA Category 1. Ninety hours of education can be

Altman, Harry E.	Pikeville	Dickson, Larry G.	Lexington
Amin, Mohammad	Louisville	Doepke, Robert H.	Morehead
Ammon, John D.	Florence	Dowden, William L.	Lexington
Archer, Raleigh R.	Lexington	Engelhard, Herbert H.	Louisville
Arterberry, Joe F.	Louisville	Ferrell, James L.	Paris
Asher, Christine A.	Trenton	Florence, Joseph A.	Hazard
Baker, Bobby C.	Ashland	Francke, Charles F.	Louisville
Baldwin, J.	Bowling Green	Franks, Larry C.	Paducah
Bardenwerper, Hulburt W.	Louisville	Frazier, Timothy C.	Louisville
Barefoot, Julius J.	Louisville	Gavin, Michael P.	Salem
Barr, Charles C.	Louisville	Gilbert, James D.	Lawrenceburg
Baumgarten, James A.	Louisville	Goodman, Roscoe M.	Williamstown
Ball, Henry R.	Elkton	Green, Steven D.	Lancaster
Beasley, John J.	Mayfield	Greiver, S. Philip	Louisville
Bell, Henry R.	Elkton	Griffith, George W.	Mount Vernon
Biagtan, Adelina C.	Louisville	Haas, Joseph F.	Ft. Thomas
Black, John S.	Bowling Green	Hafendorfer, Daniel L.	Louisville
Bloom, Karen L.	Louisville	Halcomb, Francis J.	Scottsville
Bloom, Steven M.	Louisville	Hallquist, Allan E.	Florence
Brackett, Jerry W.	Irvine	Hammerbeck, Carol M.	Louisville
Buckspan, Randy J.	Louisville	Hammons, Stanley	Lexington
Bybee, David E.	Lexington	Harrison, John W.	Ashland
Campbell, Mark R.	Trenton	Howell, Robert S.	Hopkinsville
Canlas, Noel D.	Henderson	Huszar, Leslie A.	London
Cash, Ralph L.	Princeton	Hutsell, Thomas S.	Louisville
Chilukuri, Vandl R.	Earlington	Isaacs, Barbara S.	Louisville
Clark, Dorothy H.	Lexington	Isele, Peter R.	Hopkinsville
Click, Charles G.	Stanford	Jansing, C. William	Owensboro
Collier, Ronald N.	Louisville	Jenkins, Van R.	Lexington
Conrad, Roberta L.	Paducah	Johnson, Robert K.	Crestview Hills
Cooper, John G.	Cynthiana	Jurich, Nicholas R.	Prestonsburg
Corwin, Hal M.	Louisville	Kappes, Paul S.	Bellevue
Cummings, Michael L.	Albany	Kelly, Prue W.	Murray
Curd, Phillip R.	Sandgap	Kim, Suk Ki	Owensboro
Dalzell, Robert C.	Owensboro	Klauburg, Kurt	Paducah
Dansby, Karen N.	Ashland	Krasnopolsky, D.	Hazard
Daus, Arthur T.	Louisville	Krishnamsetty, R.	Lexington

in Category 2 which includes CME lectures and seminars not designated Category 1; medical teaching; articles, publications, books, and exhibits; and nonsupervised CME such as self-instruction, consultation, patient care review, and self-assessment. Credit hours are based on hour-for-hour participation in a continuing medical education activity with the number of hours rounded to the nearest whole hour

We congratulate these physicians who have distinguished themselves and their profession by their commitment to continuing education. *KMA*

Lee, Edmund S.	Louisville	Schiavone, Robert P.	Louisville
Lindberg, Robert D.	Louisville	Schmidt, Carl J.	Louisville
Litt, Larry M.	Bowling Green	Schmitt, James L.	Ft. Thomas
Logan, John A.	Henderson	Sewell, H. Price	Jackson
Luftman, Martin J.	Lexington	Shockey, James S.	Pikeville
Lynn, Nicholas J.	Lexington	Simon, Frank G.	Louisville
MacCarthy, Justin	Glasgow	Skaggs, William M.	Louisville
MacDougal, Bruce A.	Madisonville	Slone, Kenneth M.	Hindman
Mangat, Devinder S.	Covington	Spratt, John S.	Louisville
Martin, Jerry W.	Bowling Green	Stege, George C.	Louisville
McClure, Larry T.	Ashland	Stillner, Verner	Lexington
Morgan, Kirk D.	Prospect	Smith, Irvin E.	Paducah
Mostowycz, Leonidas	Lexington	Smith, Stephen Z.	Louisville
Nayak, Irvathur N.	Hazard	Stork, Leslie F.	Frankfort
Newton, William D.	Lexington	Sublett, James L.	Louisville
Norfleet, Richard H.	Cynthiana	Sullivan, Gerald E.	Bowling Green
Offutt, William	Lexington	Taylor, Michael A.	Paducah
Ortines, Cesar G.	Louisa	Thomas, Hollis A.	Louisville
Parell, William M.	Lexington	Thornton, Lauren E.	Ft. Campbell
Parker, James E.	Louisville	Tuong, Chuong V.	Louisville
Past, Wallace L.	Jackson	Turns, Danielle M.	Louisville
Payne, Vaughn W.	Louisville	Van Bussum, Robert R.	Lexington
Payton, Christopher F.	Louisville	Vasconez, Henry C.	Lexington
Peterson, Hugh R.	Louisville	Verdi, Gerald D.	Louisville
Potter, Johnny R.	Ashland	Warren, Bryan P.	Owensboro
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Rankin, Charles E.	Lexington	Weiss, Jeffrey A.	Louisville
Ravenscraft, Howard L.	Hebron	Wham, Richard A.	Henderson
Redinger, Richard N.	Louisville	Whitt, John J.	Louisville
Rees, Allan H.	Louisville	Williams, Cordell H.	Hazard
Reid, Robert L.	Owensboro	Wittman, William L.	Lexington
Riehm, John G.	Louisville	Womack, Glenn R.	Flemingsburg
Rowlett, William M.	Hopkinsville	Woolley, Robert B.	Lexington
Roy, Sunil C.	Whitesburg	Yancey, William E.	Louisville
Saha, Sibu Pada	Lexington	Zenger, George H.	Louisville
Sajadi, Kooros	Lexington		
Saw, Andrew M.	Madisonville		



---

**PEOPLE**

Alliant Health System has announced the election of **John D. O'Brien, MD**, to the Methodist Evangelical Hospital Foundation Board of Trustees.

**Elizabeth A. Amin, MD**, director of diagnostic radiology at the James Brown Cancer Center, and **Hollis A. Thomas, Jr, MD**, chairman of diagnostic radiology at the U of L School of Medicine, recently joined their colleagues in celebrating the first birthday of U of L's Mobile Breast Care Unit. The unit, a modified mobile home, travels to businesses, malls, and public health fairs to provide on-site mammography. In the first year of operation, unit technicians performed 1,600 mammograms at 30 different locations.

**John Spratt, MD**, was reappointed to the editorial board of *Louisville Medicine*, the journal of the Jefferson County Medical Society, and named to the editorial board of *Executive*, the journal of the American Academy of Medical Administrators.

The KMA Board of Trustees has reappointed **A. Evan Overstreet, MD**, as editor of the *Journal of the Kentucky Medical Association*. Other reappointments to the *Journal* were **Daniel W. Varga, MD**, scientific editor; **Stephen Z. Smith, MD**, assistant scientific editor; **Milton F. Miller, MD**, **Martha Keeney Heyburn, MD**, **Jannice O. Aaron, MD**, and **William P. Hoagland, MD**, assistant editors.

The following KMA member physicians have been appointed to the staff of the University of Louisville: **Judith Axelrod**, assistant professor, pediatrics; **Susan Hertweck**, instructor, obstetrics and gynecology; **Daniel Arnold**, assistant clinical professor, family practice; **Paul Tittel**,

assistant clinical professor, diagnostic radiology; and **Juliana Hayden** and **Rance Wentworth**, instructors, medicine.

---

**UPDATES**
**Notice to KMA Members**

In the past few years, KMA has recommended the services of the Dodson Insurance Group to our members as a workers' compensation insurance provider. Dodson Insurance Group has recently voluntarily notified KMA that its A. M. Best rating has been changed from B+ to B. Best is an independent service which rates private insurance carriers.

KMA has received no complaints from its members regarding the services provided by the Dodson Group. Questions regarding the rating change should be directed to the Dodson Group at 1-800-825-3760.

**Tiniest Vessels May Hold Clues to Major Diseases**

According to University of Louisville physiology professor **Patrick D. Harris, PhD**, the tiniest blood vessels may hold the keys to understanding society's leading killers. Harris and hundreds of scientists and clinicians discussed the role of those blood vessels at the Fifth World Congress for Microcirculation held recently at U of L. Participants revealed research results in areas such as cancer, diabetes, heart disease, and environmental hazards.

---

**NEW MEMBERS**

*Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.*

**Daviess**

**Richard L. Gruenewald, MD** — **ONC**  
Mercy Medical Pl, Owensboro 43201  
1972, U of Missouri

**Greenup**

**Wayne B. Wheeler, MD** — **EM**  
2105 Sandstone Dr, Portsmouth, OH  
45662  
1980, U of Illinois

**Graves**

**Thomas G. Russell, Jr, MD** — **FP**  
PO Box 511, Mayfield 42066  
1985, U of Mississippi

**Harlan**

**John R. Lowe, MD** — **P**  
PO Box 148, Harlan 40831  
1974, U of Arkansas

**Jefferson**

**Thomas Brown, MD** — **P**  
7400 LaGrange Rd #410, Louisville  
40222  
1979, U of Louisville  
**Walter L. Sobczyk, MD** — **PD**  
601 S Floyd #602, Louisville 40202  
1983, U of Nebraska

**Northern Kentucky**

**William B. Hoppenjans, MD** — **D**  
743 Meadowview Dr, Villa Hills 41017  
1987, U of Kentucky

**New In-Training**
**Jefferson**

**Tracey S. Corey, MD** — **PTH**  
**Lal Suresh, MD** — **PD**

**DEATHS****Ahmad Hatam, MD  
Louisville  
1923-1991**

Ahmad Hatam, MD, a radiologist, died August 7, 1991, while vacationing in Sweden. Dr Hatam graduated from the University of Geneva, Switzerland in 1953, and was a professor of diagnostic radiology at the University of Louisville. He was an inactive member of KMA.

**Louis B. Sternberg, MD  
Louisville  
1910-1991**

Louis B. Sternberg, MD, a retired pediatrician, died August 18, 1991. Dr Sternberg graduated from the University of Cincinnati College of Medicine in 1934. He was a past president of Jefferson County Pediatrics Society and a life member of KMA.

**Alvin M. Churney, MD  
Louisville  
1926-1991**

Alvin M. Churney, MD, a retired pediatrician, died August 25, 1991. A 1953 graduate of the University of Louisville School of Medicine, Dr Churney was an associate professor of pediatrics at the University and was a Fellow of the American Academy of Pediatrics. Dr Churney was a life member of KMA.

**E. Frederic Smock, Jr, MD  
Louisville  
1926-1991**

E. Frederick Smock, Jr, MD, a retired radiologist, died August 27, 1991. Dr Smock graduated from the University of Louisville in 1958 and was a past president of the Daviess County Medical Society. He was a life member of KMA.

# CAGE Questionnaire

For the Diagnosis of Alcoholism

- C** = Have you ever felt you should **cut down** on your drinking?
- A** = Have people **annoyed** you by criticizing your drinking?
- G** = Have you ever felt bad or **guilty** about your drinking?
- E** = Have you ever had a drink first thing in the morning (**eyeopener**)?

---

Positive CAGE Answers:

1 = Suggestive 2 = Probable 3 and/or 4 = Diagnostic

---

**KENTUCKY MEDICAL ASSOCIATION**  
**Committee on Impaired Physicians**  
**301 N Hurstbourne Pky, Ste 200**  
**Louisville, KY 40222-8512**  
**(502) 426-6200**



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**Send advance payment with order to:** The Journal of KMA, 3532 Ephraim McDowell Drive, Louisville, KY 40205.

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**WANTED: HOUSE PHYSICIANS** — to contract for daytime coverage of a university affiliated municipal hospital in Charleston, South Carolina. Base salary and incentive. For details contact Drs J. Brzezinski or D. Fox at 803/793-2541.

**PURDUE UNIVERSITY STUDENT HEALTH CENTER** — is seeking a BC/BE physician to provide primary care in an active university health setting serving a student population of 36,000. Health care and prevention services are offered through out-patient and women's clinics, urgent care facilities, mental health service, physical therapy department, and a progressive health promotion/patient education program. This full-time, 12 month appointment offers excellent fringe benefits, including a generous vacation/holiday package, CME allowance, malpractice coverage, an outstanding retirement program, medical insurance, and a light call schedule. Applicants should have a strong interest and/or experience in working with college students. Please call or send CV to James S. Westman, PhD, Director, Purdue University Student Health Center, West Lafayette, IN 47907, phone 317/494-1720. EEO/AA.



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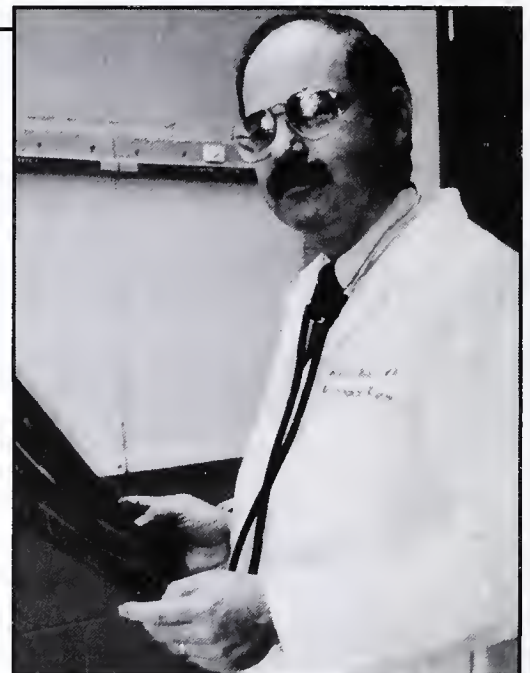
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## OCTOBER

**26 — The New Anti-Depressants at the Hyatt on Capitol Square, Columbus, OH.** Contact: The Ohio State University, College of Medicine, Center for Continuing Medical Education, A-352 Starling Loving Hall, 320 West Tenth Ave, Columbus, OH 43210-1240; 614/292-4985.

**27-November 1 — Twenty-Second Family Medicine Review — Session III;** Hyatt Regency Hotel, Lexington, KY. Contact: Ms Joy Greene, Director CME, 132 College of Medicine Office Bldg, U of K, Lexington, KY 40503-0086; 606/233-5161.

## NOVEMBER

**4-8 — 57th Annual Scientific Assembly of the American College of Chest Physicians,** San Francisco Marriott and the Moscone Center, San Francisco, CA. Contact after June 20, 1991: American College of Chest Physicians, Division of Education, 3300 Dundee Rd, Northbrook, IL 60062-2348; 708/498-1400.

**15-16 — 25th Annual Newborn Symposium and 5th Fall Symposium of the Kentucky Pediatric Society,** The Seelbach, 500 Fourth Ave, Louisville, KY. Contact: Lynette McInnis, 502/588-5329.

**16-19 — Southern Medical Association's Annual Scientific Assembly,** Georgia World Congress Center and Atlanta Hilton and Towers, Atlanta, GA. Contact: SMA, 800/423-4992.

## 1992

## JANUARY

**16-18 — American Academy of Pain Medicine's 1992 Annual Conference,** Registry Hotel, Scottsdale, AZ. Contact: Carol Endicott, American Academy of Pain Medicine, 5700 Old Orchard Rd, 1st Floor, Skokie, IL 60077-1024; 708/966-9510.

# Sizing Up Employee Benefits

**The AMA recommends a minimum health care benefits package that responds to many needs, particularly small business.**

Consider the advantages of a no-frills, minimum benefits package.

For small business employees, who make up a large percentage of America's 33 million uninsured, it can mean the difference between receiving basic health care insurance coverage and none at all.

For small business employers, it can mean the ability to provide employee health care insurance — without being forced out of business by excessive costs.

The Health Access America proposal calls for a federal law requiring all employers to provide health insurance for their employees. To help businesses fulfill this obligation, the AMA recently defined a minimum level of coverage that offers substantial benefits at reduced premiums.

The AMA Minimum Benefits Package helps small businesses afford employee health care coverage — even if those benefits don't include all the bells and whistles.

Big businesses, spurred by labor, have traditionally used

generous health care packages to attract the best workers — making the most of tax incentives and a large employee base that makes a large corporation attractive to insurance companies.

As a group, small businesses frequently pay more per employee. The big culprits in higher costs are state-mandated benefits. Studies indicate that benefit mandates add up to 20% to the cost of health insurance.

So, another aspect of Health Access America is a recommendation to eliminate mandates while still another would create state risk pools.

The Minimum Benefits Package, in combination with AMA-backed tax incentives and credits for small employers, is a major initiative to extend access to care to the millions of working uninsured.


## Benefits Highlights

- Pre- and post-natal care
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- Emergency treatment
- 45 hospital inpatient days
- Dialysis
- Selected home health services


Basic deductible:  
\$350 individual  
\$750 family

A message from The American Medical Association for the Health Access America Proposal







*"Nah,  
I've smoked  
for  
30 years.  
It's too late."*




*"I've tried a  
million times,  
but I just  
can't."*




*"I'll  
quit  
next  
week."*




*"I'll quit  
next year."*




*"What difference does  
it make? I'm already  
52 years old."*



*"It's one of the  
few pleasures  
I have left."*



*"I've got  
other things  
to worry about."*



*"The damage  
is done."*

## **They know why they can't. Now tell them how they can.**

Too many older smokers are still making excuses instead of making a determination to quit. And while most of them know about the more common long term effects of smoking, far too few of them know the facts about the immediate health benefits of quitting.

As a doctor, you can play a unique role in getting your older patients who smoke to quit for good. Take a little extra time and educate your patients about the immediate benefits of quitting. Like a decreased risk of heart attacks and strokes. Improved circulation. And most of all, the years they can add to their lives.

So listen to their reasons for not quitting, then go ahead and give them the facts.

**Let them know:  
it's never too late to quit.**

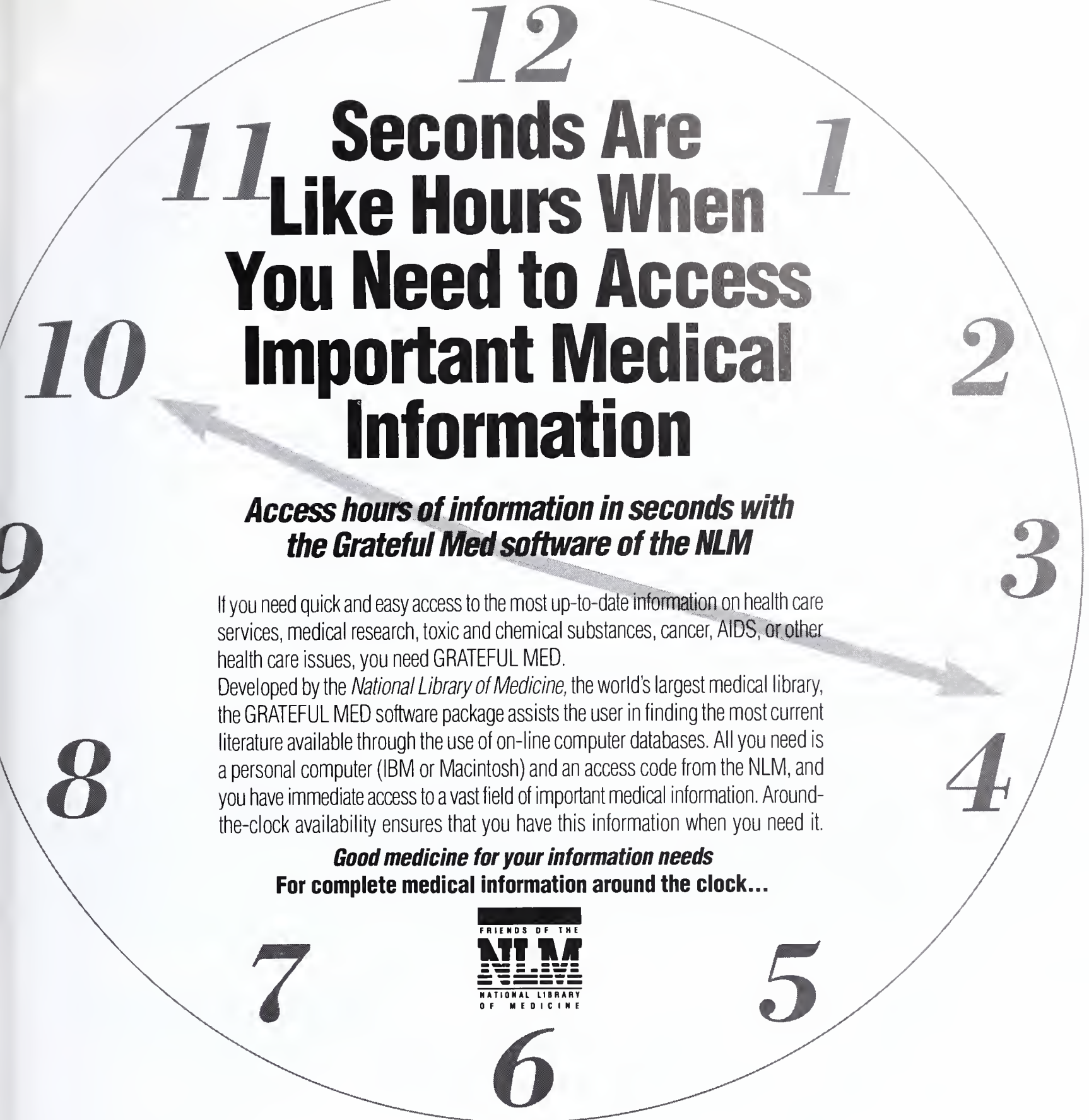
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4733 Bethesda Avenue, Suite 530, Bethesda, MD 20814  
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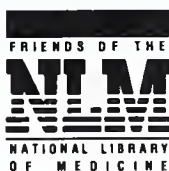
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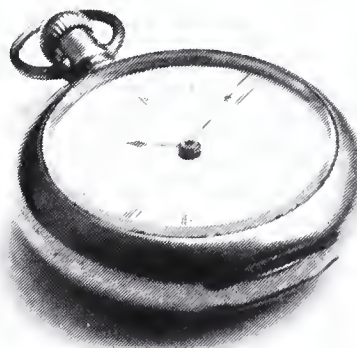


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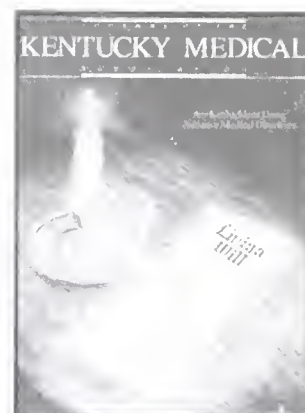


JOURNAL OF THE  
**KENTUCKY MEDICAL**  
ASSOCIATION

VOLUME 89, NUMBER 11

NOVEMBER 1991

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**COVER:** Cover illustration by Lee Wade introduces an article on page 547.

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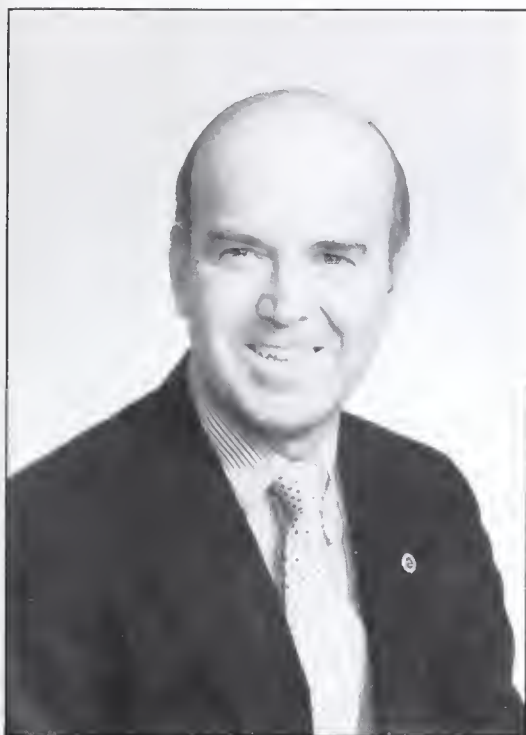
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## The Year Turns

**W**ell, the KMA Annual Meeting is over and it was an excellent meeting.

First, I would like to give much credit and accolades to our KMA staff. They all gave 100% and were available at all times to assist those attending the meeting, as well as handling all of the detail work necessary for the meeting to run smoothly. Few of us realize how much work our staff does to organize and conduct these meetings.

Also, I would like to thank Fayette County for hosting the meeting this year. Although there were some unfortunate problems with room reservations, due to a new computer system installed just prior to our meeting, it should not be a problem in the future. The Hyatt staff was apologetic about the delays and were courteous, friendly, and helpful at all times. The Fayette County Medical Society worked very hard to assure good attendance at the meeting and their work was much appreciated. They also provided excellent programs for our entertainment. The trip to the Kentucky Horse Park was educational and very entertaining. The trip to Keeneland and a chance to attend the football game at U of K were wonderful packages arranged for our enjoyment by Fayette County — if you did not take advantage of these special events you really missed a wonderful opportunity. I want to thank Preston Nunnally, MD, Immediate Past President of KMA, and Carolyn Kurz, Executive Director, Fayette County Medical Society, for their efforts in putting these programs together for us.

Now that the Annual Meeting is over, we have our work to do for the coming year. I outlined in my inauguration speech those lines of endeavor which I feel we should pursue. We must put our efforts into the theme for this KMA year which is "Prevention." I am sure we all recognize that this is at least a large part of the solution to health care cost and access to health care. Also we need to improve our physician-patient relationship and our public image. We have the methods to do this and can do it by utilizing those principles of professionalism that we already have at hand. Lastly we must all become more involved in our medical associations and their activities. We must work to get our colleagues who do not belong to organized medicine to join and become active in their component societies. We have a legislative year coming up and will need your help and support as there will be a number of health care issues proposed and decided upon in this legislature.

I look forward to working this year with our new President-Elect William Monnig, Vice-President Ardis Hoven, and Chairman of the Board Russell Travis, and the other members of the Board of Trustees. There is much work to do on the horizon, but with our officers and your encouragement and cooperation, we should be able to attain our goals.

**S. Randolph Scheen, MD**  
KMA President

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***“There is much work to do on the horizon, but with our officers and your encouragement and cooperation, we should be able to attain our goals.”***

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# Are Kentuckians Using Advance Medical Directives?

Dallas M. High, PhD; Howard B. Turner, MSW

*Findings of a statewide survey indicate that only 9% of Kentucky adults are completing Living Wills and an equal percent are designating Health Care Surrogates. Designed to protect patient's rights of self-determination in treatment decisions and protect physicians and other health care professionals from liability in complying with patient wishes, only 37% of the state's residents know about Kentucky's Living Will and 24% know about the Designation of Health Care Surrogate. In view of the results, it is recommended that educational efforts be undertaken, changes in legislation occur to ease advance medical directive access and use, and that, following customary medical practice, legislation be enacted to provide authorization of family members to serve as substitute health care decision makers for incapacitated patients.*

**I**N 1990 Kentucky enacted two advance medical directives known as the Living Will and the Designation of a Health Care Surrogate. Kentucky became the 41st state to legally acknowledge that "all adults have the fundamental right to control the decisions relating to their own medical care, including the decision to have medical or surgical means or procedures calculated to prolong their lives provided, withheld, or withdrawn" (KRS 311.622). In addition to providing adult patients with a means to instruct physicians on medical care, the legislation protects physicians, personnel acting under the direction of a physician, and health care facilities from criminal and civil liabilities when complying with the declared wishes of a terminally ill patient to withhold or withdraw life-prolonging treatment. Yet, a 1991 statewide survey shows that only 9% of Kentuckians are using each of the legally authorized advance medical directives. Only 37% of Kentucky's adults know about Kentucky's Living Will and only 24% know about the Designation of a Health Care Surrogate.

## Methods

The survey had four basic aims: (1) To ascertain whether Kentuckians were familiar with Living Wills and designation of Health Care Surrogates; (2) To measure the level of knowledge concerning recent legislation of advance directives; (3) To find out whether Kentuckians are using advance medical directives; (4) To examine the reasons offered for not using advance directives. The project was part of a larger series of studies concerning health care decision making now being conducted at the University of Kentucky Sanders-Brown Center on Aging. The University's Survey Research Center conducted 646 telephone interviews with randomly selected Kentuckians. Those surveyed ranged in age from 18 to 89 and represented all geographic regions of the Commonwealth. The margin of error for the survey was less than 4%.

## Results

As shown in Fig 1, 67% of Kentucky's adults were familiar with or had heard of a Living Will, but only 37% knew that the Commonwealth legally recognized a Living Will. Twelve percent reported

*From the Sanders-Brown Center on Aging and the Department of Philosophy, University of Kentucky, Lexington, KY 40506.*

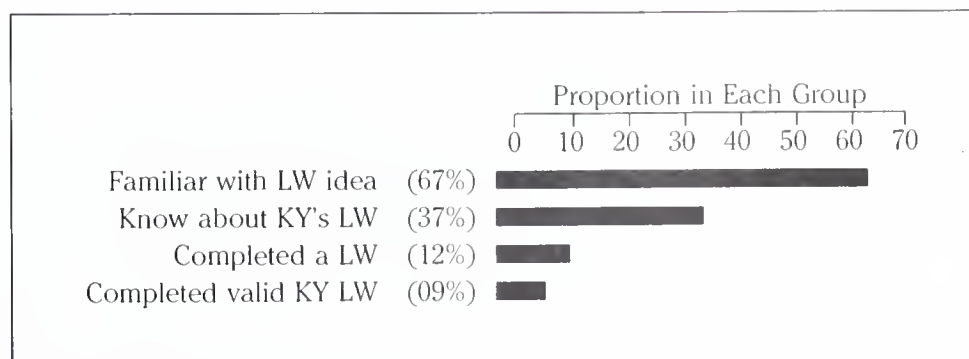


Fig 1 — Kentuckians and the Living Will (LW)



they had completed a Living Will, whether Kentucky's or some other advance directive, though only 9% indicated that their completed Living Will could be considered valid in Kentucky, having been both witnessed and notarized. Education and income levels were significant factors in familiarity with the idea of a Living Will and in knowledge of Kentucky's legislation. For example, 92% of those with at least a college education were familiar with Living Wills while only 44% of those with less than a high school education knew about them. Sixty percent of those with a college education or more knew that Kentucky recognized a legally binding Living Will while only 25% of those with less than a high school education had such knowledge. Twenty-five percent of those with at least a college level of education had completed a Living Will of some kind compared to only 7% of those with less than a high school education. When respondents were asked if their completed Living Wills were in compliance with Kentucky law the percentages became 19 and 6, respectively. A similar trend was reported for levels of income. For example, 84% of those with family incomes above \$40,000 were familiar with the Living Will while only 57% with incomes of less than \$15,000 were familiar. Age, gender, race, geographical region, and marital status were not significant factors.

For two reasons the study anticipated that familiarity with the idea of appointing a surrogate and knowledge of Kentucky's health care surrogate act would not run as high as the Living Will: (1) The Designation of a Health Care Surrogate is generally less well publicized than the Living Will and (2) the language employed in the act differs from the designation of a power of attorney. As indicated in Fig 2, 62% of the respondents indi-

cated they were familiar with the idea and only 24% knew about Kentucky's Health Care Surrogate act. Somewhat surprisingly, 20% reported that they had, by some means, appointed a health care surrogate, though only 9% could report that their designation was in compliance with Kentucky law. Although less pronounced than with the Living Will, educational levels were factors in general familiarity with the idea of designating a health care surrogate and in making an appointment in compliance with Kentucky law. Persons over 65 and those who were widowed exhibited rates significantly higher than all others for designation of a surrogate (27% and 32% respectively), as well as reporting that their appointments were in compliance with Kentucky law (18% and 20% respectively). Income levels, gender, race, and geographic regions were not significant factors.

### Discussion

The relatively low use of Kentucky's new advance directives should not be interpreted as a lack of interest in having these ethical-legal instruments available or that they are undesirable for health care planning. As reported in this *Journal* in 1988, 77% of adult Kentuckians favored legislation permitting "doctors to honor the written instructions of their patients concerning treatment, even if a terminally ill patient wishes to have life-sustaining procedures withheld or withdrawn."<sup>1</sup> A statewide survey conducted in 1990 found that the number had increased to 85%.<sup>2</sup> That survey also found that 83% of Kentuckians favored having a law that would allow them to appoint a specific person to make health care decisions for them in the event they could not personally make them, including decisions continuing or discontinuing life-sustaining treatment. In addition, 81% of Kentuckians answered yes to the question "Do you think Kentucky should have a law that would authorize family members or other representatives to make health care decisions for you if you cannot make decisions for yourself and you have not written out your wishes in advance?" However, the low usage is not surprising when compared to the experience of other states which have legislated advance directives. State and national surveys conducted through 1989 reveal usage rates ranging from 4% to 17%, with an average of less than 10%.<sup>3,4</sup> Kentucky's rate of use appears consistent with that of other states.

In order to measure some of the reasons for the lack of advance directive use respondents

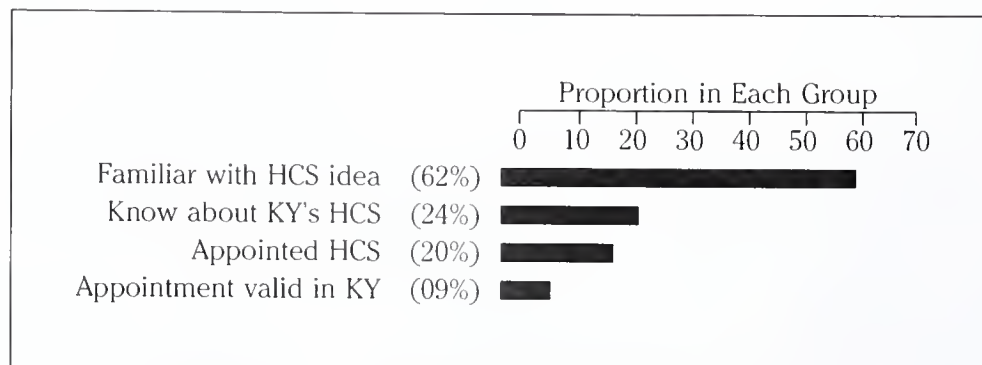


Fig 2 — Kentuckians and the Designation of a Health Care Surrogate (HCS)

in the present study were asked, "Which of the following reasons would you say best describes why you don't have a Living Will?" A similar question was asked concerning the Designation of a Health Care Surrogate. Of those familiar with a Living Will but had not executed one, 57% of the respondents indicated that they "plan to, but haven't done it yet," 15% "did not think that it was necessary," 14% indicated that they "did not have enough information," and 7% "did not trust how it would be used." The remaining 7% volunteered a different answer or did not know. Of those familiar with the Designation of a Health Care Surrogate but had not appointed one, 37% indicated that they "plan to, but haven't done it yet," 28% "did not think it was necessary," 19% "did not have enough information," and 6% "did not trust how it would be used." Eleven percent volunteered a different answer or did not know.

It is a natural tendency for people to delay decisions which are unpleasant, especially if those decisions appear to be in the distant future. However, for our sample, "putting off" any planning for decisional incapacity was not an age related factor. That is, the elderly appeared to procrastinate as much as the younger respondents. The significant percentage of the sample who did not think advance directives were necessary also was not age related, ie, the younger respondents did not hold that opinion more than elderly respondents. Widowed persons, however, were less likely to think the designation of a health care surrogate was unnecessary. This suggests that underlying procrastination and thinking advance directives unnecessary, is a belief that family members can be relied on to make health care decisions for decisionally incapacitated relatives. Indeed, more than 90% of all persons of all ages prefer that a family member serve as surrogate if needed.<sup>1,5</sup> Physicians, attorneys, friends, and others are each preferred less than 5% of the time. As expected, persons aged 18-30 predominantly choose spouse and/or parent; persons 31-65 predominantly choose spouse and/or adult child; and persons over 65 predominantly choose adult child and/or spouse. Moreover, studies<sup>5,6</sup> indicate that people prefer and expect to rely on informal means of surrogate decision making rather than to execute formal directives.

The expressed preferences for family members to serve as surrogates on an informal basis coincides with the long-standing and customary medical practice of deferring to relatives in the event the patient is unable to consent to or refuse

medical treatment. This includes consultation with family members when considerations of withholding or withdrawing life-sustaining treatment are involved. Unfortunately, in most states there is a legal uncertainty surrounding the reliance on family members for surrogate consent or refusal. Because of this, and in an effort to honor the direct wishes of a patient through advance direction, Living Wills and appointments of legal proxies have been regarded by many as appropriate remedies and as means of providing protection to physicians in carrying out difficult decisions to forgo life-sustaining treatments. However, like others throughout the nation, Kentuckians appear not to be using advance directives at any effective rate.

Ironically, the relatively low rate of use continues to occur even at a time when a high level of interest in advance directives has been generated by the US Supreme Court's landmark decision in the Nancy Cruzan case. That decision denied Cruzan's parents the authority to decide to withdraw medically administered nutrition and hydration without presentation of "clear and convincing evidence" of the patient's own wishes. The high rate of interest is corroborated by two national organizations (*Concern for Dying* and *The Society for the Right to Die*) devoted to advocating the rights of the terminally ill<sup>7</sup> which report an increased request for Living Will forms by 500%. A recent empirical study indicates that 93% of outpatients and 89% of the general public are interested in some form of advance directive.<sup>3</sup> However, it should be noted that there is a difference between people *saying* they are interested, or even requesting copies of advance directive forms, and sitting down and completing these instruments when it is known that the directives will potentially affect their health care.

It may well be argued that educational efforts are needed to inform patients and their families of the availability of Living Wills and the mechanism for appointing a surrogate. Perhaps the acceptance and use of advance directives could be increased if they were promoted and publicized. To date, however, there have been no studies to determine what methods of promotion and education regarding advance directives are the most effective. On the other hand, it can be inferred from the present study that educational efforts would increase the use most among persons with higher educational and income levels. If so, the middle class bias already present in advance directive use would be exacerbated.<sup>8</sup> At



the very least, those with an advanced education are most likely to use directives and appoint surrogates because these instruments place a premium on skills of articulation and experience with legal documents. Since the laws apply to all classes of people, not only should the advance directive instruments be made available to everyone, but the ease of use should be facilitated by recognizing differences among people.

The Patient Self-Determination Act (1990) will address some of these problems<sup>9</sup> since that federal legislation requires hospitals, nursing homes, and other institutions serving Medicare and Medicaid patients to provide information about advance directives and patient rights to accept or refuse treatment. The act further mandates that a national educational campaign be conducted to inform the public of its rights to participate in decisions concerning medical care and the existence of advance directives. The impact of this legislation could be substantial, but longitudinal research will be required to determine both the positive and negative consequences. In the meantime, Kentucky should consider additional and alternative efforts to facilitate the use of advance directives and support patient control. These efforts should acknowledge that many people will simply not plan ahead for health care decisions.

### Recommendations

To minimize confusion and maximize access, Kentucky's advance directives should be made more consistent with one another in at least two areas: 1. The Living Will requires that the document be *both* notarized and witnessed by two persons whereas the Designation of a Health Care Surrogate requires *either* that it be notarized *or* witnessed by two persons. The latter procedure is more convenient for patients and should be followed for both instruments. 2. The statute for Designation of a Health Care Surrogate allows, within limits, for the withdrawal of artificially provided hydration and nutrition. The current Kentucky Living Will prohibits such decisions. Not only are the two statutes inconsistent, but in the light of the US Supreme Court ruling in the Cruzan case (1990), the restrictions are constitutionally suspect. Moreover, the restrictions are not consistent with the American Medical Association's Council on Ethical and Judicial Affairs<sup>10</sup> which endorses forgoing nutrition and hydration in certain circumstances.

Unfortunately, an increasing number of patients are becoming decisionally incapacitated who may not qualify under Kentucky's Living Will requirement for having a "terminal condition." These patients include those with advanced dementia of the Alzheimer's type and patients in a persistent vegetative state. Currently, more than 10% of persons over 65 suffer from Alzheimer's disease.<sup>11</sup> Consideration needs to be given to providing these patients with instruments for advance written medical directives to accept or refuse treatment. Such instruments would not only serve to protect the personal treatment wishes to which these patients are entitled but would prove helpful to physicians in dealing with and honoring those treatment wishes.

Finally, it must be acknowledged that even with changes in advance directives to facilitate their use, not all of us will formally document our wishes or designate a surrogate. State law must recognize this reality and permit families to act for those who do not execute advance directives or who specifically desire that family members act for them in the event of incapacity. Consequently, statutory authorization of family members to serve as substitute health care decision makers for incapacitated patients is urgently needed. Such legislation would recognize and empower the customary medical practice of obtaining consent from family members when a patient is not personally able to make a decision. This provision, sometimes described as a family consent law, should establish a priority list of appropriate family surrogates authorized to make substitute health care decisions. Patients could opt for this provision by taking no action, or in the event an individual wished to reject the presumption of family authorization in substitute decision making, a Living Will or a designation of another surrogate could be instituted.

The recommended provision not only follows customary medical practice but is fully consistent with Kentuckians' overwhelming desire to have family members make health care decisions when someone else must make a decision for them.<sup>5,6</sup> Family members can be presumed to be the best substitute decision makers since they likely have the most knowledge about and concern for the relative. In addition, authorization of family substitute decision making would help to overcome the apparent middle-class nature of Living Wills and formal appointments of surrogates, providing an appropriate alternative for patients

less well-educated or less economically advantaged.

The survey results presented here make it abundantly clear that Kentuckians are not completing Living Wills or designating health care surrogates in any appreciable numbers. Changes in the advance directive approach and the use of an alternative procedure are warranted to assist patients to exercise their fundamental rights of self-determination in health care and to assist the medical profession in appropriately treating patients who can no longer make health care decisions for themselves.

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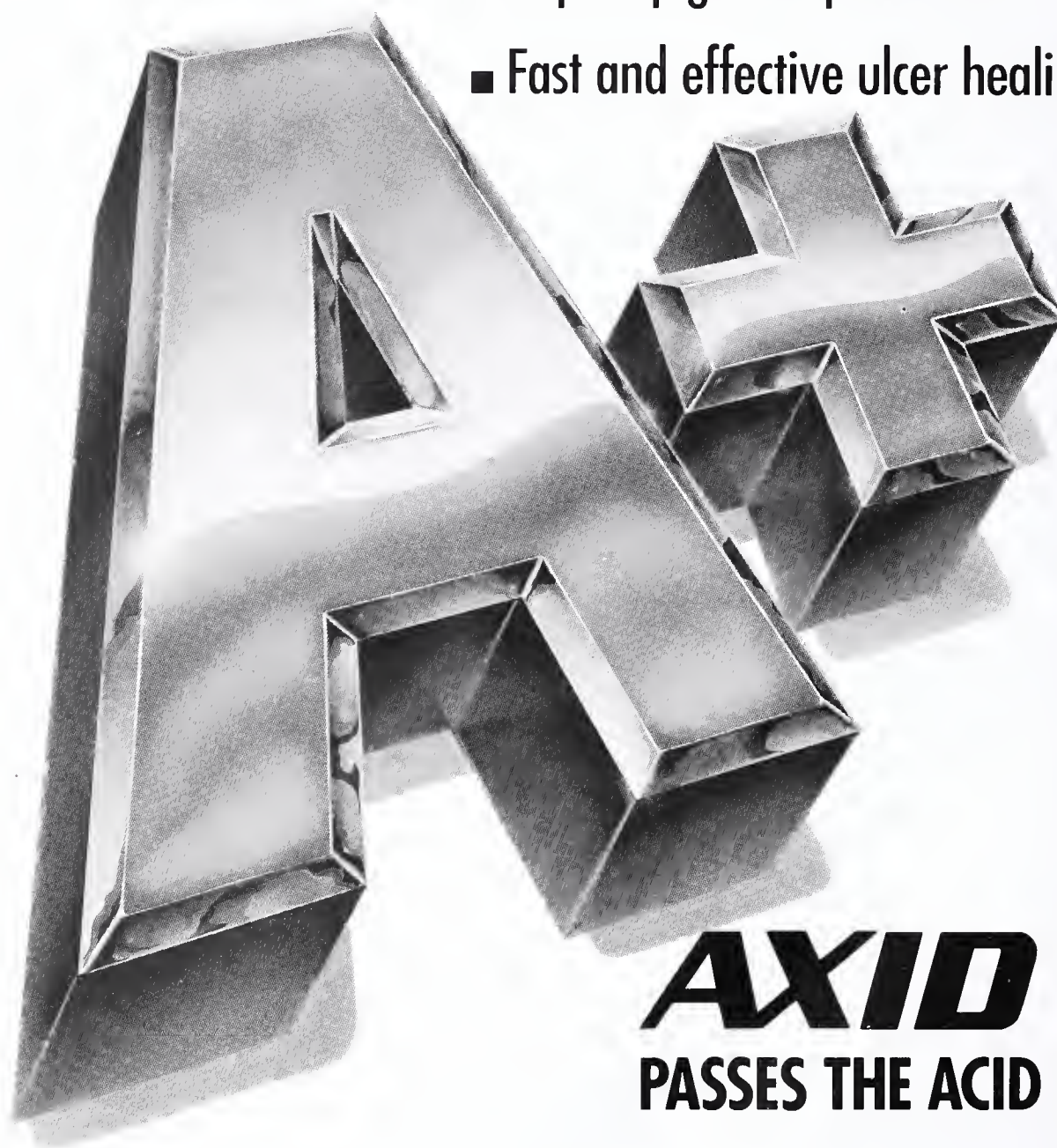


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Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

**Pregnancy—Teratogenic Effects—Pregnancy Category C:** Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect, but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

**Nursing Mothers:** Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

**Pediatric Use:** Safety and effectiveness in children have not been established.

**Use in Elderly Patients:** Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

**Adverse Reactions:** Clinical trials of varying durations included almost 5,000 patients. Among the more common adverse events in domestic placebo-controlled trials of over 1,900 nizatidine patients and over 1,300 on placebo, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common with nizatidine. It was not possible to determine whether a variety of less common events were due to the drug.

**Hepatic:** Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

**Cardiovascular:** In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

**CNS:** Rare cases of reversible mental confusion have been reported.

**Endocrine:** Clinical pharmacology studies and controlled clinical trials showed no evidence of androgenic activity due to nizatidine. Impotence and decreased libido were reported with equal frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

**Hematologic:** Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H<sub>2</sub>-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

**Integumental:** Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

**Hypersensitivity:** As with other H<sub>2</sub>-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

**Other:** Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

**Overdosage:** Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis does not substantially increase clearance of nizatidine due to its large volume of distribution.

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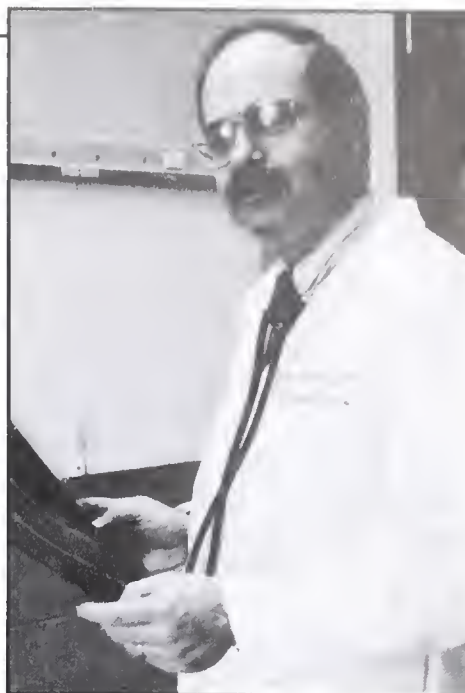
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# Acquired Factor VIII Inhibitor

William G. Simpson, MD; John Neefe, MD; Jerry Zang, MD;  
Randy Drosick, MD; Ross Kearns, MD

**A**cquired inhibitors of coagulation factors are circulating pathologic antibodies, directed at specific coagulation factors, whose action results in a clinically apparent bleeding disorder.<sup>1</sup> Antibodies to factor VIII have been demonstrated in both hemophiliacs and nonhemophiliacs. Among persons afflicted with severe hemophilia A, approximately 6% to 8% develop circulating inhibitors of factor VIII.<sup>1</sup> The development of an acquired factor VIII inhibitor in nonhemophiliacs remains, however, quite rare. We describe a case involving such an inhibitor.

## Case Report

A 64-year-old white male presented to the emergency department complaining of the onset of easy bruising, with little or no associated trauma. He had no prior history of bleeding. Over the days just prior to presentation the patient had developed tightness of the skin and deep bruises over bilateral thenar eminences, bilateral anterior calves, and the superior aspect of the left trapezius muscle. There was no history of melena, hematochezia, hematuria, or mucosal bleeding. Previous tooth extractions were uneventful. The patient denied recent use of any medication, especially nonsteroidal anti-inflammatory agents or Coumadin. He reported a history of alcoholism, hypertension, coronary artery disease, and rectal prolapse requiring surgical management 8 years prior. There was no family history of bleeding disorders. Exam revealed a thin white male in no distress; the vital signs were stable. Fundi were normal, and there was a left subconjunctival hemorrhage. A large ecchymosis covered the left flank. The spleen was not palpable. The extremities were covered with numerous ecchymoses, including involvement of bilateral thenar eminences, bilateral anterior compartments of the calves, and the superior aspect of the left trapezius muscle. The rectum was prolapsed, and the stool was positive for occult blood.

The serum electrolytes were normal. Hematocrit was 40.7%, the mean corpuscular volume was 105, and the platelet count was 205,000/mm<sup>3</sup>. The leukocyte count was 14,000/mm<sup>3</sup>, with a normal differential. Neither rheumatoid factor nor antinuclear antibody were detectable. The prothrombin time (PT) was 10.6 sec (control 11.8 sec); the activated partial thromboplastin time (aPTT) was 50.3 sec (control 26.4 sec); and the thrombin time was 12.8 sec (control 10.8 sec). A bleeding time of 9.0 min was determined (normal range 2.3 to 9.5 min). Fibrinogen was 240 mg/dl (normal 200-400 mg/dl), and fibrin split products were less than 40 ng/ml. The level of factor IX:C was >100%, while that of factor VIII:C was <1%. A factor VIII inhibitor was present at 4.5 Bethesda units/ml.

The diagnosis of acquired factor VIII inhibitor was made. The patient continued to develop new intramuscular hemorrhages. He received factor IX concentrate, 3000 U intravenously every 4 hours for a total of 12,000 U. At the same time immunosuppression was begun, employing prednisone (60 mg/day) and cyclophosphamide (150 mg/day). No new lesions developed after the first day. On the fourth hospital day the PTT decreased to 37.0 sec (control 26.0 sec) and the factor VIII inhibitor level was 1.0 Bethesda unit/ml; the cyclophosphamide was discontinued. The patient was discharged on prednisone on the sixth hospital day much improved. One month after the patient left the hospital his PTT was normal at 25.4 sec, factor VIII:C level was within normal range, and there was no detectable factor VIII inhibitor.

## Discussion

Patients with acquired inhibitors of factor VIII present with bleeding complications characteristic of those found in classic hemophilia, including easy bruising, hemorrhage into muscles and soft tissues, epistaxis, hematuria, melena, uterine bleeding, and even hemarthroses.<sup>1,2</sup> Initial labora-

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## Acquired Factor VIII Inhibitor

tory evaluation reveals prolongation of the PTT and whole blood clotting time, while other coagulation studies, including the PT, are normal.<sup>3</sup> Such a presentation in an individual not previously known to have an inherited clotting disorder suggests the presence of an acquired inhibitor. Screening for a factor VIII inhibitor and assay of the factor level should be undertaken. Simple screening can be performed by mixing normal plasma with the plasma in question in equal parts and evaluating the aPTT in the mixture.<sup>3</sup> A prolonged aPTT supports the presence of a circulating inhibitor. Finally, the inhibitor titer should be established employing the Bethesda method (see ref 3 for details). The amount of inhibitor which will inactivate 0.5 U (50%) of normal factor VIII level is defined as one Bethesda unit.<sup>3</sup>

Acquired inhibitors of factor VIII are immunoglobulins of the IgG type. Those developing in hemophiliacs tend to be restricted in the number of both light and heavy chains expressed, as compared to the normal heterogeneity of IgG molecules in nonhemophiliacs.<sup>4</sup> Infusion of exogenous factor VIII in hemophiliacs with acquired inhibitors results in an anamnestic antibody response, a phenomenon which usually does not occur in nonhemophiliacs.<sup>2,5</sup>

Acquired inhibitors to factor VIII in a non-hemophiliac are associated with a variety of clinical conditions (Table), including mostly other autoimmune disorders. Such antibodies can also develop in the postpartum period in otherwise healthy females. Some patients, commonly elderly, have no detectable underlying disease.<sup>1,6,7</sup>

General information pertaining to the course and management of nonhemophiliac patients with acquired factor VIII inhibitors is limited by the lack of controlled prospective trials. Green and Lechner<sup>7</sup> surveyed physicians and collected data from 215 cases, 164 (87%) of which presented with serious bleeding complications (hemarthroses, melena, hematuria, intracranial, or retroperitoneal hemorrhage). Forty deaths (22%) were attributable to the presence of uncontrollable bleeding. The complex kinetics of antigen-antibody interaction displayed by these inhibitors make simple replacement therapy unsuccessful.<sup>1</sup> Thus, several alternatives have been proposed. Plasmapheresis prior to factor VIII replacement rarely results in a sufficient reduction in circulating inhibitor levels to allow replacement therapy to achieve hemostasis.<sup>8</sup> The use of factor VIII derived from nonhuman species, such as porcine or bovine, offers the potential

**Table.** Disease States Associated with the Development of Acquired Factor VIII Inhibitors\*

<i>Inflammatory Bowel Diseases</i>
Ulcerative colitis
Regional enteritis
<i>Collagen Vascular Diseases</i>
Rheumatoid arthritis
Rheumatic heart disease
Temporal arteritis
Systemic lupus erythematosus
Polymyositis
Dermatomyositis
<i>Malignancy</i>
Leukemia and lymphoma
Solid tumors
<i>Post-partum</i>
<i>Drug Reactions</i>
Pencillins
Chloramphenicol
Sulfa drugs
Phenytoin
<i>Dermatologic Conditions</i>
Exfoliative dermatitis
Psoriasis
Pemphigus
<i>Miscellaneous</i>
Diabetes
Sarcoid
Asthma
Hepatitis
Idiopathic

\*References 1, 6, 7

of achieving hemostatic concentrations of factor due to reduced antigen-antibody interaction.<sup>2</sup> Prothrombin complex concentrates, which include the vitamin K dependent factors, have also been employed to achieve hemostasis in patients with acquired factor VIII inhibitors.<sup>1,2,3,6</sup> The specific component of prothrombin complex concentrates responsible for bypassing factor VIII activity may be the activated factor VII or activated factor X.<sup>1</sup>

The efficacy of immunosuppression in the long-term management of these patients with inhibitors remains difficult to assess. Among the series reported by Green and Lechner,<sup>7</sup> either partial or complete resolution of the inhibitor occurred in 22 of 45 (49%) patients receiving steroids alone; in 19 of 28 (68%) patients receiving steroids and azothioprime; and in 37 of 72 (51%) patients receiving steroids and cyclophosphamide, as compared to spontaneous resolution in 11 of 31 (35%) untreated patients. Remission was achieved in 73% (8/11) of patients with inhibitors treated with cyclophosphamide, with or without

prednisone, by Green et al.<sup>9</sup> Those with low inhibitor titers (<10 BU/ml) responded uniformly (7/7), while patients with higher titers (>10 BU/ml) appeared less responsive (1/4). Herbst et al.<sup>10</sup> report six nonhemophiliac patients with clinical bleeding attributable to factor VIII inhibitors. All six patients responded to a combination of prednisone and cyclophosphamide, with clearing of inhibitor between 7 and 55 days after initiation of therapy. Five patients initially presented with inhibitor titers < 4 BU/ml. A patient with an initial titer of 19 BU/ml had a more protracted course, failing cyclophosphamide alone and subsequently responding to cyclophosphamide and prednisone. Lian et al.<sup>11</sup> recently reported a series of 12 nonhemophiliac and five hemophiliac patients with acquired factor VIII inhibitors in whom factor VIII infusion was followed by cyclophosphamide, vincristine, and prednisone (FVIII-CVP). Among the nonhemophiliacs initial inhibitor titers ranged from one to 139 BU/ml, and FVIII-CVP resulted in disappearance of the inhibitor in 92% (11/12) with no recurrence. Although spontaneous remissions may occur, the risk of bleeding in patients with an acquired factor VIII inhibitor is great, favoring the use of immunosuppressive therapy.

## Summary

Development of a circulating inhibitor of the coagulant activity of factor VIII is a rare event producing a clinical picture similar to that of classic hemophilia. A case of autoimmune factor VIII inhibitor has been presented. Although a hemostatic response was rapidly achieved with the in-

fusion of factor IX concentrates, immunosuppressive therapy was initiated. The inhibitor disappeared in less than 20 days from the initiation of therapy.

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# Thoracic Empyema Due to *Streptococcus intermedius*

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*With improved laboratory identification procedures, Streptococcus milleri (intermedius) is becoming recognized as an important human pathogen with the potential to form abscesses in a wide range of organs. The occurrence of a rapidly progressive and toxic empyema due to this organism in an otherwise healthy young adult without a predisposing lower respiratory tract infection allows us to examine the possibility that this microbe may be a significant but frequently unrecognized cause of adult empyema.*

## Introduction

**S**treptococci other than *Streptococcus pneumoniae* account for less than 1% of adult pneumonias, and are implicated in only 10% of empyemas.<sup>1</sup> The setting usually involves aspiration of gastric or oral contents with resultant pneumonia or lung abscess. The streptococci are commonly found in association with other facultative or anaerobic organisms.

Hematogenous seeding of the pleura also may rarely result from bacteremia from a more distant site of infection with and without endocarditis.<sup>2</sup>

*Streptococcus milleri* comprises a heterogeneous group of organisms with characteristic biochemical reactions that provide a mechanism for more accurate grouping within the general classification of viridans streptococci.<sup>3,4</sup> *Streptococcus intermedius* is a subspecies of the *S milleri* family, but both names have been used interchangeably in the medical literature to refer to the same microorganism. The nomenclature has been inconsistent because American and British taxonomists have employed slightly different schemes for classification of the viridans streptococci. Additionally, many clinical laboratories have only recently become interested in more exact identification of the nontypeable strepto-

cocci. For the purpose of this report, *S intermedius* is recognized as being synonymous with *S milleri*.

*S intermedius* is a microaerophilic organism that constitutes part of the endogenous oral flora. Although previously identified as a pathogen in necrotizing pneumonia and lung abscess, it has also rarely been associated with the development of spontaneous empyema without prior pulmonary infection.<sup>6</sup>

We report a patient who presented with a significant empyema due to *S intermedius* that was refractory to antibiotic therapy and drainage by tube thoracostomy. Surgical decortication was required for cure. This patient's presentation and clinical course allow us to reexamine the role of *S intermedius* as a potential pleural pathogen.

## Case Report

J. F., a 38-year-old black male, was admitted with severe pleuritic chest pain that had begun suddenly 4 days earlier. He also admitted to dyspnea, low grade fever, and lightheadedness. His chest discomfort was worsened by his usual "smoker's cough," but the cough was productive of only scant amounts of sputum. He denied hemoptysis and chills. He denied all prodromal symptoms suggestive of either a recent upper or lower respiratory infection. He denied exposure to other persons with known infections. The patient had no recent exposure to recreational or environmental toxins, but had smoked cigarettes for 13 years. He denied any chest trauma or dental manipulations. His history was negative for any risk factors for pulmonary embolism.

The patient was in moderate distress with a respiratory rate of 32 breaths per minute, an oral temperature of 102°F, and a pulse rate of 100 beats per minute. Blood pressure was stable at 110/80 mm Hg in the supine position. Examination of the oral cavity documented very poor dental hygiene with multiple caries. The patient

splinted his respiratory movements of the left side. Breath sounds were absent over most of the left hemithorax which was also dull to percussion. Egophony and tactile fremitus were diminished. The remainder of his examination was unremarkable.

Additional data available in the emergency department included a chest radiograph that showed a large pleural density that obscured the left hemidiaphragm and allowed only slight aeration of the left upper lobe (Fig 1). His electrocardiogram was normal. The patient was hypoxemic with a PaO<sub>2</sub> of 54 torr on room air with a normal PaCO<sub>2</sub> and pH. The total white blood count was 12,600 with 71% granulocytes, 3% band forms, 18% lymphocytes, and 7 monocytes. Hemoglobin was 16.4 gm/dl with a hematocrit of 46.7. There was no toxic granulation or Dohle bodies present on the peripheral smear.

The patient was admitted for further evaluation of his fever and massive pleural effusion. On the first hospital day, a diagnostic bedside thoracentesis was performed. Approximately 280 cc of straw colored pleural fluid was removed with difficulty, as the fluid was felt to be loculated. This fluid was exudative and contained 370 white blood cells which were predominantly granulocytes. Cefotaxime was started intravenously pending microbiologic studies on the pleural fluid.

The chest was imaged by CT scan on the second day. The large left loculated pleural effusion was identified. There was no evidence of infiltrates, tumors, nodules, or other parenchymal pathology. The mediastinum was unremarkable.

The patient remained febrile and uncomfortable despite 48 hours of intravenous antibiotics, which now included 2 million units of penicillin every 4 hours. Gram stains done on sputa, blood, and pleural fluid were unremarkable.

A second thoracentesis was performed and was again exudative. A pH done on this fluid was 7.04, suggesting the possibility of an empyema. Because of the presence of loculations and pleural fluid chemistries consistent with an infected pleural cavity, two large bore chest tubes were inserted for drainage (Fig 2).

On the third hospital day, the microbiology laboratory reported that the first pleural fluid sample was culture positive for *Streptococcus milleri* (*intermedius*).

The patient failed to defervesce as expected after tube thoracostomy and on the seventh hospital day was taken to the operating room for thoracotomy and decortication. A large gelati-



Fig 1 — Admission chest film with massive left pleural based density.



Fig 2 — Incomplete drainage of the left pleural cavity despite tube thoracostomy.

nous peel that was densely adherent to the visceral pleura of the entire surface of the left lung was removed. This material (Fig 3) was also cul-



## Thoracic Empyema



Fig 3 — Organized fibropurulent material removed at decortication. (Trichrome stain 400x)

ture positive for *S milleri (intermedius)*.

The patient subsequently improved and was afebrile by the third postoperative day. He was discharged from the hospital on the eighth postoperative day with a fully reexpanded left lung (Fig 4).

### Discussion

Seeding of the pleural cavity by hematogenous or direct spread of a bacterial microorganism may result in a purulent inflammatory exudate termed thoracic empyema. Gram positive bacteria are the most common cause of empyema, followed by gram negative aerobic and finally the facultative anaerobic bacilli. As a general rule, the organisms that cause empyema are the same bacteria involved in necrotizing pneumonia and lung abscess. Indeed, these two conditions are usually precursors of a secondary infection of the pleural space. Although modern treatment of pneumonia and lung abscess has significantly reduced the incidence of pleural infection to less than 1%, empyema may also occur if microorganisms are introduced hematogenously into the pleural space from a distant focus of infection without preceding pulmonary parenchymal involvement.<sup>2</sup>

In many clinical laboratories, all non-beta hemolytic streptococci which are not grouped A, B, or D by the Lancefield typing system are referred to as "viridans streptococci." These organisms are common inhabitants of the human mouth, nasopharynx, gastrointestinal tract, and vagina, with an isolation rate of 15% to 30%.<sup>7</sup> They are classified as facultative aerobic streptococci and may be inadvertently dismissed by the clinician as a contaminant. As laboratories have improved their ability to classify and subspeciate microorganisms, several subgroups of the viridans streptococci have been identified as causing human disease. These include *Streptococcus milleri*, *S mitior*, *S mutans*, *S salivarius*, and *S sanguis*. The true spectrum of disease produced by individual species of the viridans streptococci is not well defined.

Overall, the most serious sequelae of these organisms are related to bacterial invasion of the blood stream of patients with congenital or acquired heart disease during manipulative procedures in the oropharynx. Transient bacteremia may occur in 80% of patients with periodontal disease<sup>8</sup> and may also produce abscess in sites other than the heart valves.

*S milleri (intermedius)* is relatively infrequently a cause of endocarditis (5%), but is the most common species of viridans streptococci associated with pyogenic infections (68%).<sup>9</sup> Additionally, it may be more virulent and cause more serious suppurative complications than other forms of viridans streptococci.<sup>10</sup> Increasing numbers of patients are being identified who present with empyema and pure isolates of *S milleri (intermedius)*.<sup>11</sup> This association with empyema correlates well with the organism's predilection for abscess formation and infected fluid cavities elsewhere in the body.

Once the pleural cavity is seeded, an unopposed infection follows a predictable evolution. Early sterilization of the pleural fluid and adequate drainage with obliteration of the cavity are essential. The earliest response to pleural fluid infection is an exudative phase with thin fluid approachable by bedside thoracentesis. Characteristic findings of pleural fluid infection that should prompt chest tube placement at this stage have been proposed<sup>12</sup> and are listed in the Table.

The fibroreticulate stage is marked by increased accumulation of polymorphonuclear leukocytes and the presence of fibrin. The high fibrin and protein quality promotes loculation and adhesions of the visceral and parietal pleura. Thora-





**Fig 4 — Chest film after decortication demonstrating full reexpansion of the left lung.**

centesis at this juncture may not be as helpful in clinicians' ability to confirm the presence of pleural infection. The previous criteria for tube thoracostomy may be unreliable in patients with loculated effusions.<sup>13</sup> The decision for chest tube placement may rest on the patient's poor response to antibiotics alone. Patient improvement is usually evident within 48 to 96 hours of successful chest tube drainage.

The final phase of an unsuccessfully treated empyema is marked by the production of an inflexible membrane termed a "pleural peel." The development of this organized peel may impart a restrictive defect to pulmonary function and continue to harbor the pathogen. Total surgical removal of the empyema sac is the only alternative to avoid the major complications of metastatic infection, perforation into the parenchyma or chest wall, and development of a persistent draining sinus.

If a febrile course persists for 7 to 10 days despite drainage and antibiotic therapy or if mul-

**Table.** Current treatment recommendations for potentially infected pleural fluid based on diagnostic thorocentesis results.

*Antibiotics and observation:*

pH >7.3  
glucose >60 gm/dl  
LDH <500 IU/L  
No organisms on Gram stain or culture

*Antibiotics and repeat thorocentesis in 12 hours:*

pH 7.1 to 7.3  
glucose 40 to 60 mg/dl  
LDH 500 to 1000 IU/L  
No organisms on Gram stain or culture

*Antibiotics and prompt chest tube drainage:*

pH <7.1  
glucose <40 mg/dl  
LDH >1000 IU/L  
Organisms found on Gram stain or culture

tiple air-to-air levels are present, surgical decortication should be considered. This procedure is optimally performed during the second or third week of infection.<sup>14</sup> Beyond that time, tufts of scar tissue may extend through the pleura into the lung parenchyma making the procedure more difficult. If thoracic empyema organization is left unattended, more extreme procedures are sometimes required such as modified thoracoplasty with resection of extrapleural contents and creation of a muscle flap.<sup>15</sup>

The literature regarding empyema secondary to *S milleri (intermedius)* suggests a strong male predominance and an early onset of severe toxic symptoms.<sup>16</sup> The progression of the pleural infection is rapid with early development of loculation and pleural thickening.<sup>17</sup> Studies also suggest that resolution will be slow. As in our report, the patient is often healthy and free of major predisposing factors for pleural infection and source of infection has not always been obvious in the few reported cases of empyema due to *S milleri (intermedius)*.<sup>18</sup>

When the empyema is due to this organism, penicillin appears to be the antibiotic of choice. However, sensitivity testing is advised in light of recent reports of penicillin-resistant clinical isolates.<sup>19</sup> The organism is variably responsive to other antibiotics frequently used to treat hospital acquired infections.<sup>20</sup>

We hope our report will alert clinicians of the emerging role of *S milleri (intermedius)* as a hematogenous source for pleural empyema and purulent infections in other body tissues and re-



emphasize the role of early pleural drainage based on pleural fluid characteristics as an essential element of treatment in association with appropriate antibiotics.

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# Yellow Nail Syndrome: A Perspective

Cheryl L. Fields, MD; Thomas M. Roy, MD; Miguel A. Ossorio, MD;  
Patricia J. Mercer, MD

*The Yellow Nail syndrome is an unusual lymphangitic disorder classically characterized by the presence of nail discoloration, lymphedema and pleural effusion. Since the recognition of the significance of these associated physical findings, four cases have been diagnosed at our institution in the last six years. This suggests that the syndrome may not be as rare as previously reported in medical literature. More often it may remain unrecognized in the absence of the classic triad of physical findings. To heighten awareness of this disorder, we describe our most recent patient diagnosed with YNS and provide a review of the current medical literature.*

## Introduction

Over 25 years ago, the association of primary lymphedema with yellow discoloration of the nails was described by Samman and White as the "Yellow Nail Syndrome."<sup>1</sup> Within 2 years, Emerson reported the coincident occurrence of pleural effusion, establishing the classic triad by which this syndrome is confirmed.<sup>2</sup> As less than 130 such patients have been described in the medical literature, the clinical significance of this disorder has yet to be determined. The association of the Yellow Nail Syndrome with immunologic abnormalities and certain neoplasms suggests that the characteristic physical findings should alert the clinician to the potential of more serious underlying disease.

## Case Report

A 45-year-old white female was referred by her primary physician for pulmonary consultation and evaluation of digital clubbing. The patient stated that the change in the shape of her nails had occurred over the preceding year. During that period a persistent yellow discoloration of her nail beds was also noted and attributed to the

use of nail polish. Although the patient described dyspnea on exertion and an occasional productive morning cough, she expressed no other medical complaints during an extensive review of systems. She had a 40-pack-year history of cigarette abuse. There was no significant occupational or recreational exposure to toxins or chemicals. She was not taking prescription or OTC medications. Her family history was unremarkable. She was unable to identify other family members with similar nail changes.

Clubbing of the upper and lower extremity digits was confirmed by physical examination. Yellow discoloration, transverse ridging and friability of the nails were found (Fig 1). Pretibial edema was present bilaterally. Late expiratory wheezes were auscultated in the right lung base. The remainder of her physical examination was unremarkable.

No evidence of parenchymal disease or pleural fluid was evident on standard chest radiograph. Electrocardiogram showed no abnormality. Spirometry confirmed the presence of early airflow obstruction. Arterial blood gas analysis while breathing room air measured the pH 7.42,  $PCO_2$  31.7 mm Hg and  $PO_2$  71.4 mm Hg. The alveolar-arterial oxygen gradient was increased at 38.7 mm Hg. Urinalysis showed no evidence of protein or abnormal sediment. An erythrocyte sedimentation rate (Wintrobe) was slightly elevated at 38 mm/hr (0-30 mm/hr). Tests for the presence of antinuclear antibodies and rheumatoid factor were negative. Thyroid function studies were normal. Her stool was free of occult blood. Bilateral mammograms were normal.

Repeated evaluations have been conducted to monitor the patient's dyspnea and airflow obstruction. Her onycholysis and nail discoloration persist. A trial of thiazide diuretic failed to eliminate or decrease the lymphedema in her lower extremities. Dermatology consult has confirmed the absence of nail infection and concurred with the diagnosis of Yellow Nail Syndrome.

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## Discussion

Full expression of the Yellow Nail Syndrome (YNS) consists of the presence of three cardinal features: yellow nails, lymphedema, and pleural effusion. Unfortunately the diagnosis is often difficult because the simultaneous occurrence of all features is rare. Less than 20% of the reported cases in medical literature manifested the complete triad.<sup>3</sup> Investigators now agree that the manifestation of two of the three traditional features justifies the diagnosis of the syndrome.<sup>4</sup> Since initially noted in 1964, approximately 130 patients have been reported in the English literature.<sup>1,2</sup> No geographic, racial or gender predominance has been established. A potential genetic predisposition has been suggested with the report of the syndrome's occurrence in siblings.<sup>5,6</sup>

The physiologic mechanism leading to the clinical features has yet to be confirmed, although several theories involving anomalies of the lymphatic system have been proposed. It has been suggested that congenitally hypoplastic lymphatics, when taxed by injury or infection, result in insufficient drainage with the development of pleural effusions and lymphedema. This theory is supported by the finding of abnormal lymphangiograms in some patients.<sup>1,2,3,7</sup> It cannot, however, be the sole explanation as abnormal lymphangiography has not been a uniform finding in the patient population that has been tested. Major lymphatic vessel stenosis has been described in some patients.<sup>8</sup> Many patients have shown no lymphatic anatomic abnormality on post mortem examination, suggesting that the kinetics of lymph flow may be disturbed by nonstructural abnormalities.<sup>5</sup>

The patient with the YNS usually presents with one of three complaints: the presence of yellow discoloration to their nails; lymphedema; or respiratory tract symptoms.<sup>6</sup> Each feature occurs with equal frequency. Those with nail discoloration also experience slow nail growth and friability. The color change is usually not evident at first. The cuticle may be absent while edema and erythema of the proximal nail fold may be seen.<sup>9,10</sup> Clubbing of the digits in the presence of these nail changes is a delayed phenomenon that has been infrequently noted.<sup>5</sup> In greater than one-third of the patients, the characteristic nail changes may precede the development of lymphedema and pleural effusions by years.<sup>3</sup>

The lymphedema that develops may be widespread, but more commonly becomes no-

ticeable in the patient's lower extremities and hands. The respiratory tract symptoms are those referable to the accumulation of pleural fluid, and those attributable to upper and lower respiratory tract infections, ie, sinusitis, bronchitis, and bronchiectasis.

The diagnosis of the YNS in the absence of the classic triad of clinical features is one of exclusion. Most laboratory evaluations will be within normal limits.<sup>6</sup> An infectious etiology for the nail discoloration can be excluded by culturing the nail clippings. Because of subsequent onycholysis in some patients, *Candida albicans* may be cultured. It is not, however, considered to be a true cause for the nail changes.<sup>11,12</sup>

The evaluation of the pleural fluid has shown it to be exudative with a cellular content of lymphocytic predominance. Pleural biopsies obtained in some patients have shown nondiagnostic inflammatory changes or a thick fibrous pleura with a lymphocytic infiltration.<sup>2,3,5,13</sup> Pulmonary function testing in most patients will reveal a combined impairment with airflow obstruction and ventilatory restriction.<sup>6</sup>

Lymphangiography was formerly performed routinely in this patient population. However, because of inconsistent findings and its inherent morbidity, it is no longer recommended.

Approximately one-third of the individuals with the syndrome will experience spontaneous resolution of the nail discoloration.<sup>9</sup> Lymphedema and pleural effusions appear to be more chronic and unpredictable in degree and duration. Only symptomatic relief can be offered. The application of topical steroids or alpha-tocopherol to the nails has met with sporadic success.<sup>14</sup> Elevation of the lower extremities has been advocated for relief of the lymphedema. Diuretic use is controversial.<sup>3</sup> Those patients with symptomatic pleural effusions experience relief with thoracentesis. Chemical pleurodesis and open pleural abrasion have been used successfully to prevent recurrence of symptomatic pleural fluid collections. The routine use of these procedures is limited by their immediate discomfort and morbidity.<sup>2,3,13</sup> A single case report regarding the efficacy of a pleuroperitoneal shunt for successful treatment of a large recurrent effusion secondary to YNS was recently published.<sup>15</sup> Larger patient trials are needed to determine its proper place in therapy for such troublesome pleural effusions.

It is difficult to establish a consensus regarding a greater clinical significance for the YNS. Many of the disorders that have been described



**Fig 1 — Patient's hands with severe clubbing and yellow discoloration of the nails.**

in association with this syndrome lack established cause and effect. Hypogammaglobulinemia, rheumatoid arthritis, and macroglobulinemia have been reported as case studies.<sup>11, 14, 16</sup> Nephrotic syndrome and thyroid disease including Hashimoto's thyroiditis and hypothyroidism have been reported and suggest an autoimmune basis.<sup>6, 17</sup> Most worrisome is the observation of an increased occurrence of certain malignancies in patients with this syndrome. The development of bronchogenic neoplasms, sarcomas, and lymphomas in patients with this disorder have led to speculation that the YNS may be a marker for occult malignancy.<sup>3, 4, 5</sup>

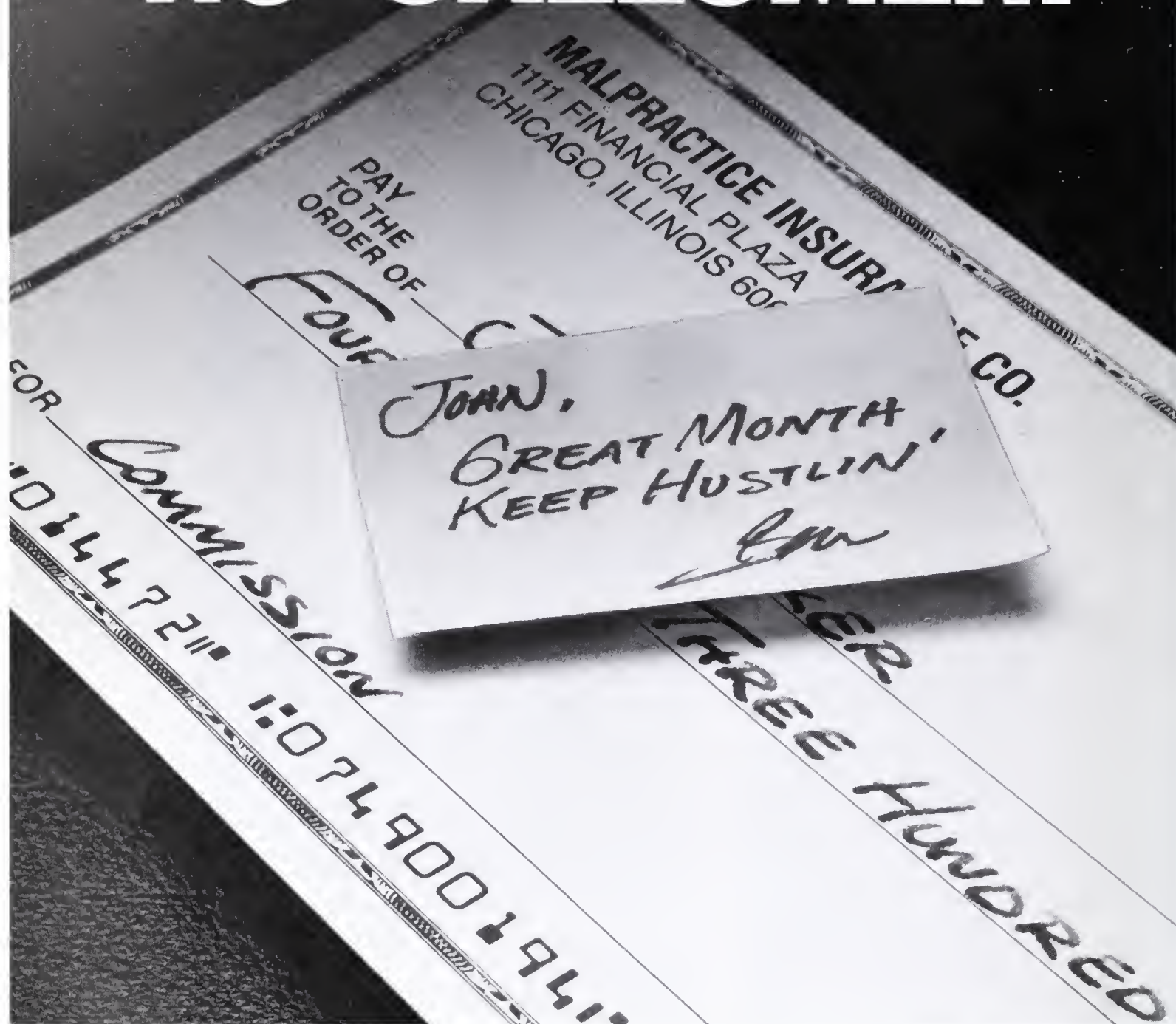
The clinical significance of the YNS will be further defined as primary care physicians become more aware of this disorder. Whether its association with certain malignancies warrants routine screening procedures for an occult tumor (chest radiograph, stool hemoccult, urinalysis, electrolyte analysis, and in women, mammogram and pelvic examination) also should become evident as more physicians gain experience with this syndrome. Its established link with thyroid disease, rheumatoid arthritis, and sleep apnea necessitates appropriate and thorough questioning and evaluation in these areas.

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# Medical Cost Containment — The Issues for 1992

**M**edical Cost Containment will undoubtedly be one of the hottest items on the agenda for the 1992 spring Kentucky Legislative Session. If we individually and collectively start now, we can significantly impact the decisions of policy makers seeking to control the medical care costs in Kentucky.

## **To effectively impact our legislatures we must:**

1. Be knowledgeable about cost containment issues.
2. Formulate opinions about the proposed legislative policy reforms or proposals.
3. Communicate these opinions to our policy makers either via our medical organizations, directly, or both.
4. Encourage development of legislature addressing issues not currently being addressed.

## **Some of the issues**

1. Kentucky has higher than the national average health care costs.
2. The health care costs may be higher in Kentucky due to increased costs of the for-profit hospitals.
3. The CON is the only mechanism for public accountability of the development of expensive medical procedures and technology.
4. The constitutionality of geographically limiting the CON process within a state.
5. The high cost of malpractice insurance. Many feel the perceived need to practice defensive medicine accounts for 5% to 20% of health care dollars in the US which could be significantly decreased by appropriate tort reform.
6. The establishment of a health information system for collecting and disseminating information. Some health care providers feel such a system enables consumers to compare the price and quality of health care services and might impact the cost of medical care. An act has been proposed by Representative Susan Stokes establishing a health information system.
7. Legislation affecting lifestyle of the individual as it impacts on his or her health. Such laws could potentially lower health care costs in the long run. For example, laws regarding seat belts, legal age for smoking, health education in the schools, or AIDS prevention could be encouraged and supported by the medical community.
8. Many issues regarding the state's or society's responsibility for providing basic health care coverage remain unresolved and may surface in the form of Medicaid reforms.

Let's make 1992 the year we include in our personal goals involvement in addressing the rising health care costs in Kentucky and impacting the decisions of our policy makers.

**Jannice O. Aaron, MD**



# **THE UNITED STATES ARMY RESERVE HEALTH CARE PROFESSIONALS BONUS TEST PROGRAM**

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## The Kentucky Cancer Program

**T**O THE EDITOR: The Kentucky Cancer Program is a statewide, cancer control program overseen jointly by the James Graham Brown Cancer Center of the University of Louisville and the Lucille Parker Markey Cancer Center of the University of Kentucky. It was established in 1982 with funding from the General Assembly.

The KCP had its origins in the McDowell Community Cancer Network which was started in 1975 by the University of Kentucky. During the next few years public and professional education was provided through regional offices located in Paducah, Madisonville, Lexington, Hyden, Somerset and Morehead. The formation of the Kentucky Cancer Program with the active participation of the James Graham Brown Cancer Center in 1982 permitted the new organization to extend to the whole state a broad range of cancer-related educational activities.

A District Cancer Council comprised of 20 to 40 lay and professional members was established in each of the 15 Area Development Districts in the state. Staffing for the District Cancer Councils is provided by Regional Coordinators each of whom lives in the vicinity of the District Cancer Councils the Coordinators serve. Regional offices are now located in Louisville, Bowling Green, and University Heights in addition to those previously mentioned. District Cancer Councils consider local cancer-related needs and establish priorities for the educational activities to be conducted in their geographic areas. Coordination of these activities is achieved by a Program Coordinator based at each of the two cancer centers. The Brown Cancer Center is

responsible for such programs in the six Area Development Districts in western Kentucky while the Markey Cancer Center has this responsibility for central and eastern Kentucky.

During the 1988-90 period there were 2,241 community programs presented in the state with 76,742 people in attendance. Programs for adults were concerned with hospice development, the formation of support groups for cancer patients and their families, increased participation in cancer screening programs, educational programs in high schools about breast and testicular self-examination, and general programs about cancer presented before service clubs, homemakers groups, women's clubs, and other community organizations. Programs for children are presented in the schools across the state, and our one-week summer camp for Kentucky children with cancer, Camp Indian Summer, has just had its 10th anniversary.

In addition to the activities of the Community Programs Division, the Kentucky Cancer Program contains the Cancer Information Service for the state and the Kentucky Cancer Registry. The Cancer Information Service is linked to the CIS Network of the National Cancer Institute and utilizes the 1-800-4-CANCER telephone line. Calls made from all parts of Kentucky are answered by the Kentucky CIS based at the Markey Cancer Center. Between 1988 and 1990 there were 12,384 calls to the CIS.

A wide variety of informational materials and public service announcements are provided to telephone callers, newspapers, radio and television stations, and others.

These activities are coordinated with the release nationally of information from the national Cancer Institute. A more complete report of the CIS activities will be provided in a subsequent issue of this journal.

The Kentucky Cancer Registry was established by the 1990 General Assembly as part of the Kentucky Cancer Program. The legislation mandated the reporting of all new cancer cases from the 113 acute care hospitals in the state using the format of the computerized Cancer Patient Data Management System (CPDMS) developed by the Markey Cancer Center. The CPDMS was started in 1986 and by 1990 was utilized by 30 hospitals in the state voluntarily reporting almost 70% of new cancer cases seen each year at these institutions. Under the guidelines established for the new Registry, each hospital will have its own registry for patients seen in that institution and will have access to aggregate, statewide cancer patient data maintained in a central registry at the Markey Cancer Center. A more detailed description of the Registry and its utilization as the basis for both professional and public cancer education will be presented in a subsequent issue of this journal.

In summary, under the aegis of the Brown Cancer Center and the Markey Cancer Center and their respective University Medical Centers, Kentucky now has a comprehensive statewide Cancer Control Program that is working effectively with the Department of Health Services, the American Cancer Society, and other health care-related organizations. The true mark of success of this cancer control effort, however, will come from the active participation of



physicians and other health care providers in its programs and in a measurable reduction in the morbidity and mortality of cervix, breast, and perhaps other cancers in Kentucky over the next few years.

**Gilbert H. Friedell, MD**  
**Michael B. Flynn, MD**

Drs Friedell and Flynn are Co-Directors of the Kentucky Cancer Program and are based respectively at the Markey Cancer Center and the Brown Cancer Center.

## Physician Payment Reform

**T**O THE EDITOR: These words are being written prior to August 1, 1991. Events relative to Physician Payment Reform (PPR) are moving so rapidly that what you read here may well be old news, completely off track.

As a physician, I am happy to say that your efforts on behalf of our patients are being rewarded. The leadership of your state medical society, the AMA, and all of the national societies is having an effect. The details known at present are subject to change (good or bad), are confidential, and of varying magnitude. Hopefully when you read this, some will be resolved and common knowledge.

Do not stop the pressure. Repeat calls and letters to your legislative contacts are in order.

PPR has many good points if budget neutrality is kept. Administration should be easier for

us; so you will reap the benefit of better administration. Do you believe that?

Now the bad news. The first months of PPR are going to be an administrative nightmare. With a reduction in administrative budget, no more people to work, we are going to be running two systems. One for claims of work done before January 1, 1992, and one for work done after this; two sets of payment for each CPT code.

It will be most helpful to you and to us to get all your 1991 claims submitted as close to January 1 as possible. Please make a great effort to post your work promptly and get it in. The sooner after January 1st we can devote all our time to the new system the less likelihood that you will have delay in payment in 1992.

I have the "Definitive Definition" of *surgical global fee* before me. But I know it is already changed. Next month perhaps it will be established enough to discuss.

A word about Durable Medical Equipment (DME). There is a Michigan company soliciting Medicare recipients in this state suggesting tens units, glucometers, and what have you; "Medicare will pay all." They are sending you "medical necessity" vouchers. Please don't acquiesce unless the patient needs it. And if they do, why not a local supplier? What this company is doing is not illegal — but you are liable for any "unnecessary" medical necessity forms you may sign.

**J.B. Holloway, MD**  
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# TOUGH, SMART AND YOURS

medical  
economics  
SEPTEMBER 1989

**S**uccessfully defending a brain-damaged baby case is the courtroom equivalent of pitching a no-hitter. Because the "sympathy factor" can add millions to a jury's award, many insurance carriers would rather settle than fight.

Not so the P-I-E Mutual Insurance Co. of Cleveland, Ohio, and the 4-year-old law firm—Jacobson, Maynard, Tuschman & Kalur—that does all its defense work. In 21 brain-damaged baby cases it has defended for the doctor-owned company, its record is a remarkable 19-1-1, the last a hung jury. In 1988, its overall record read 33 wins, 3 losses—all malpractice cases.

There's more to those numbers than luck "Or even legal skill," adds JMT&K founding partner Aaron Jacobson, who was one of Ohio's leading plaintiffs' lawyers before he, Larry E. Rogers, Herbert S. Bell, M.D., and 70 other Cleveland doctors formed P-I-E in 1975.

"It's the concept behind the firm that makes it work. Physician specialty panels review every lawsuit to decide whether the defendant deviated significantly from the standard of care. If he did, we pay. If he didn't, we defend. Makes no difference whether it's a \$5,000 or a \$5 million case. We label it 'No pay.' That policy has resulted in a lot of cases being dropped. Perhaps more important, it's

## DON'T YOU WISH THESE DEFENSE LAWYERS WERE YOURS?

This big, multistate firm rarely loses a case. But it's more than luck, or even legal skill, that's behind its enviable record.

By Howard Eisenberg

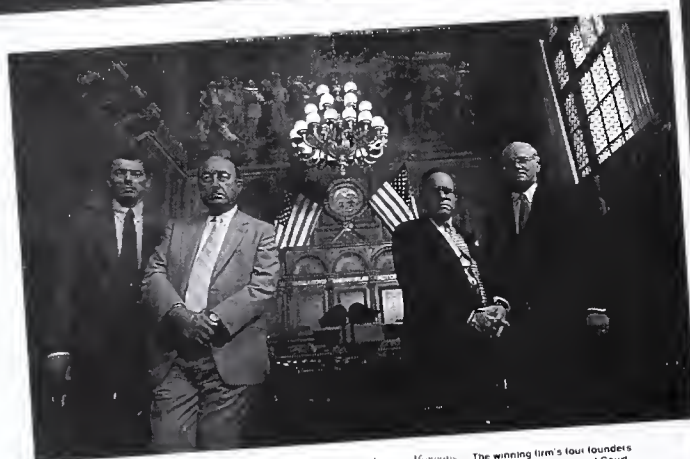
discouraged the filing of many other cases. Plaintiffs' attorneys have learned that we're fair negotiators when our doctor's in the wrong, but won't hark down when he's right."

That approach pays off. "According to the most recent report I've seen from the General Accounting Office," says Larry Rogers, P-I-E president and CEO, "in 1984, about 57 percent of medical malpractice claims were closed without payment. Through 1988, we've closed an average of 78 percent of our cases without a dime changing hands. And it's my understanding that, without including defense costs, St. Paul Fire and Marine Insurance Co.'s 1988 average gross payout for cases closed in Ohio with payment was \$52,500. Our comparable figure was about \$10,000 below

theirs. That's partly why we can sell an ORG spendist in Ohio—an industrial state that ranks among the most litigious—\$1.2 million in coverage for just \$26,400."

The unique marriage of P-I-E and JMT&K has been so successful that the carrier has expanded into five other states: Indiana, Kentucky, Maryland, Missouri, and West Virginia. Where P-I-E goes, there goes JMT&K, with nine branch offices to date. The firm has 65 trial attorneys, and may well be the nation's largest devoted well-nigh exclusively to medical malpractice defense.

Could the insurer-defender symbiosis, if duplicated by other doctor companies, make a significant contribution to reducing malpractice litigation nationwide? An up-close look at



How JMT&K operates may help to answer that question.

### Every lawyer develops a medical specialty

"Our firm's lawyers read more medical books than law books," says P-I-E Vice President Gerard C. O'Connell, himself a veteran defense attorney. Robert Maynard explains, "New cases are discussed at our weekly staff meeting, so that every lawyer is familiar with every case. But we assign cases to our attorneys according to medical specialty. They're well-versed in their fields, so they don't have to reinvent the wheel with each case."

Last year, the firm's ORG specialist, attorney Jerome S. Kalur, who had won 10 consecutive brain-damaged baby cases, faced one of his toughest challenges when he defended a GP

who'd attempted a midforceps delivery that ended in a Caesar section and a severely brain-injured baby. Recalls Kalur, "I didn't think the doctor had caused the damage, but our position was weakened by the fact that he didn't have midforceps privileges. Based on that departure from the standard of care, our doctor panel voted to settle, and, since the hospital was also involved, a combined sum of \$1.5 million was offered. Plaintiffs turned us down flat."

"I wanted to depose the doctors who'd been involved in the mother's care during her hospitalization, but the attorney for the plaintiff baby insisted it would violate the mother's physician-patient confidentiality. That privilege would terminate automatically when her medical

The winning firm's four founders at Cleveland's 8th District Court of Appeals (from left): Jerome S. Kalur, Aaron Jacobson, James M. Tuschman, and Robert Maynard.

records were introduced at the trial end of the plaintiff's case. Meanwhile, I was in the new position of having to tell the jury, 'It couldn't have been the jury,' without offering them another reasonable brain-damage theory."

Fortunately, the plaintiffs rested their case on a Friday afternoon, giving JMT&K time for a weekend rally. "Twenty minutes later," says Kalur, "I was in the hospital pathologist's office with an order permitting me to view the mother's placental slides. Mesenteric staining had been charted, and Kalur had a hunch that fetal distress had begun long before the for-

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## *The Serious Sides of Sex*

*Editors: Neville Blakemore & Neville Blakemore, Jr*  
*Specialty Editors: Stanley A. Gall, MD; Arthur H. Keeney, MD, DSc; Robert L. Stenger, Theod, JD; Michele H. Ubelaker, PhD, JD; Wayne Oates, PhD; Virginia Keeney, MD*

*The Nevbet Company, Louisville, Kentucky, 1991*

**T**his comprehensive, informative book is an excellent complement to the existing literature of this field. It has a unique anatomy, which facilitates its purpose of discussing current sexual information from medical, legal, ethical, and psychological perspectives. Specialty editors take turns at presenting the information on a given topic in sequence, permitting the reader to have continuity in reading the material and to use the book as a reference work.

Initial chapters introduce the concept of a multidisciplinary discussion. Sexual options are presented candidly and without prejudice. Sexual behavior is explained literally, but not in the genre of the "how-to" books. Rather the discussion is both practical and comforting, with the knowledge and language being very informative. Even condom information is dissected from the four perspectives and is

remarkably free of behind-the-drugstore counter distance!!

A substantial corpus of the book is used in delineating sexually transmitted diseases — 80 plus pages!! Use of the term "social diseases" is unlike the rest of the book, which takes more of a medical high ground. Current information on syphilis, scabies, gonorrhea, etc is descriptive, especially the legal aspects. Ethical dilemmas with these diseases are interesting to consider with the subsequent discussion of AIDS, hepatitis, and herpes infection. The press and volumes of literature seemed to be consumed with articles about these diseases, and the reader will be given a very careful discussion from each set of editors about this. In fact, this part of the book may be the most useful in helping the physician to improve his ability to care for patients with these problems.

Next are 56 pages dealing with pregnancy, including unlawful

intercourse, conception, full-term pregnancy, unwanted pregnancy, and abortion. The last topic is taken on despite the inherent controversy swirling around it today. Read this section several times and you come away better informed and better able to consider both sides of the question.

The glossary is a glorified dictionary of terms, but its juxtaposition to the text is planned for the audience whose background varies. Finally, an index is included and really makes the book more textbook, and less sensational. Why the editors put on the back cover "A No-Nonsense, Interdisciplinary Book about the Birds and the Bees Useful to Everyone," is not obvious. Nevertheless, buy this book and read it carefully.

Please address any correspondence:

**Stephen Z. Smith, MD**  
 906 Rugby Place  
 Louisville, KY 40222-5642



## NOVEMBER

15-16 — 25th Annual Newborn Symposium and 5th Fall Symposium of the Kentucky Pediatric Society, The Seelbach, 500 Fourth Ave, Louisville, KY. Contact: Lynette McInnis, 502/588-5329.

16-19 — Southern Medical Association's Annual Scientific Assembly, Georgia World Congress Center and Atlanta Hilton and Towers, Atlanta, GA. Contact: SMA, 800/423-4992.

Kentucky Thoracic Society 37th Annual Scientific Conference on Pulmonary Disease call for abstracts on pulmonary ventilation for any scientific aspect of respiratory disease. For additional information call the American Lung Association, 1-800-366-LUNG.

## JANUARY 1992

16-18 — American Academy of Pain Medicine's 1992 Annual Conference, Registry Hotel, Scottsdale, AZ. Contact: Carol Endicott, American Academy of Pain Medicine, 5700 Old Orchard Rd, 1st Floor, Skokie, IL 60077-1024; 708/966-9510.

## MARCH

6-7 — 35th Annual Postgraduate Ophthalmology Symposium; Diabetes Mellitus; Ophthalmic Perspectives; Hyatt on Capitol Square, Columbus, OH. Contact: 800/492-4445.

## JUNE

1-3 — 60th Assembly of the Southeastern Surgical Congress, Atlanta, GA. Presentations and posters should be submitted by November 15, 1991. Contact: Roger Sherman, MD, Secretary Director of the Southeastern Surgical Congress, 69 Butler St Southeast, #314, Atlanta, GA 30303.

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## A Message From Sherry S. Strebel, 1991-92 AMAA President

*The Auxiliary to the Kentucky Medical Association is a member of a federation of county, state, and national auxiliaries. The following message is presented to all physician spouses from the American Medical Association Auxiliary President, Sherry S. Strebel.*

If I could, I would like to speak to each of you personally to share with you my thoughts on the importance of the medical auxiliary. Since that isn't possible, I'd like to share with you the message I will be taking around the country this year as I visit in the states and counties. And that message is "That each of us has the opportunity to make a difference if we are committed to a cause and if we're willing to risk our involvement for that cause. And when people with like minds work together, they can do more than make a difference — they can change the world."

Certainly the auxiliaries in Kentucky continue to do your part in making a difference in your communities with your efforts on behalf of fund raising for the American Medical Association Education and Research Foundation, in promoting sound health legislation, and in providing outstanding health programs in your community.

I would ask your help in another area this year — and that is in family violence. The AMA has called on the auxiliary to be leaders in addressing this issue because it has become a health concern of epidemic

proportions. I urge you to become involved in a three-point program to address this problem — in education to make people aware of family violence and its consequences; in support for victims; and in providing resources to physicians to share with their patients who are victims.

Last year, we began a campaign to enhance the image of the medical profession through promoting media coverage of the volunteer efforts of physicians and spouses. This year we are continuing that campaign and calling on those relationships we built with the media — newspapers, radio, and TV — to gain recognition for the wonderful health projects and programs auxiliaries are providing to the community.

Of course, to do all of this, we need people who are committed to make a difference through our causes — as leaders, as committed individuals who are willing to become involved, and as members who can support our efforts with their dues. All are necessary to make the difference that we as auxiliaries do the best — the difference for our families, for our communities, for our nation, and for the world.

I hope each of you will help us by renewing your membership in your local, state, and national auxiliaries. Together we can change the world.

*Sherry S. Strebel*



# 1991 KMA Annual Meeting Highlights

The 141st meeting of the Kentucky Medical Association concluded October 3, 1991. During the Annual Meeting, 24 specialty groups held sessions and the House of Delegates convened on two occasions. The President's Luncheon featured the installation of Louisville dermatologist S. Randolph Scheen, MD, as the 141st President of KMA. Attendees also honored outgoing President Preston P. Nunnelley, MD.

The Luncheon also featured the presentation of the Distinguished Service Award to KMA Past President Leroy C. Hess, MD, an Erlanger family physician. Ardis D. Hoven, MD, Lexington infectious disease specialist, was the recipient of the KMA Educational Achievement Award.

The House of Delegates elected William B. Monnig, MD, an Edgewood urologist, as President-Elect. Dr Monnig will assume the office of President at the 1992 Annual Meeting. Other elections included Ardis D. Hoven, MD, Vice-President; Ronald E. Waldrige, MD, Shelbyville, 7th District Trustee; Donald R. Stephens, MD, Cynthiana, 9th District Trustee; and Donald J. Swikert, MD, Florence, and J. Gregory Cooper, MD, Cynthiana, AMA Alternate Delegates. Russell L. Travis, MD, Lexington, will serve as Chairman of the Board of Trustees.

Listed below are highlights of actions taken by the House of Delegates. Readers are reminded that only a brief summary of Committee actions or Resolutions enacted are included. We refer you to the December 1991 issue of the KMA *Journal* where text of the Committee Reports and Resolutions is printed in full.

- Gave KMA Board of Trustees authority to restructure KMIC ownership so that a holding company can be established providing KMIC flexibility to become a part of a larger group of companies, should that be desirable.
- Approved continuation of the Kentucky Physicians Care Program.
- Established guidelines for specialty groups participating in the KMA Annual Meeting.
- Recommended that CHR provide a video tape to physicians offices on Breast Cancer Options.
- Approved recommendation that KMA support legislation to ban all fireworks except professional displays.
- Directed KMA to seek resolution to the issue of hospitalization or denying nursing home admission for MRSA-diagnosed patients.
- Expressed appreciation to the Kentucky Department for Health Services and the leadership of Reginald Finger, MD.
- Adopted guidelines on HIV testing for physicians and HIV-infected physicians.
- Urged the Kentucky General Assembly to prohibit students in grades 7-8 from participating in varsity soccer, football, and wrestling.
- Adopted position opposing corporal punishment in schools.
- Recognized patriotism of medical personnel serving in Operation Desert Storm.
- Encouraged hospital medical staffs to choose representatives and actively participate in the KMA Hospital Medical Staff Section.
- Directed KMA to evaluate other states that allow only physicians to credential physicians; alert members of economic credentialing and its effect on physicians' practices; and joined AMA in opposing economic credentialing.
- Directed KMA to develop model medical staff bylaws and/or guidelines suitable for Kentucky and make them available to hospital medical staffs upon request for an appropriate fee.
- Endorsed legislation opposing the use of billboards or other mediums which advertise tobacco products visible from school property (K-12); restricting tobacco vending machine use to persons 18 years and older; mandating local health departments to provide smoking cessation clinics to children under 18 in areas where similar classes are not available.
- Encouraged KMA to work with the State Department of Health to disseminate radon guides to physicians and other appropriate information on other health hazards to educate patients and work to standardize and measure reporting of radon levels.
- Complimented KMA's Legislative Committee for efforts in assisting AMA's campaign to block HCFA's rejection of the RBRVS agreement.
- Recommended KMA support efforts to develop a separate Impaired Physicians Committee Office with a full-time Medical Director.
- Opposed any new legislation or proposal permitting nonphysicians to perform laser surgery.
- Urged the federal government to overturn Medicare fee discrimination against new physicians and to treat all physicians fairly.
- Directed that DNR orders in the prehospital setting be developed and incorporated into state statutes.
- Opposed publication of rape victims names.
- Opposed gag rules in pregnancy options counseling or any other similar intrusion into the doctor/patient relationship.
- Directed KMA to assume a leadership role in a task force on health costs and problems facing the current health care system in Kentucky.
- Voted to exclude Kentucky's participation in the Medicare select policy program and urged that HMOs conform to Medicare supplement guidelines as originally developed by the National Association of Insurance Commissioners.
- Recommended that KMA develop close communications with the

Kentucky PRO to help settle disputes and work to achieve local meetings between the PRO and physicians on a regular basis.

- Directed KMA to continue to seek budget neutrality in regards to RBRVS as originally proposed and agreed.
- Endorsed the concept that Kentucky be treated as a one-fee area.
- Took action to encourage uniform health education and physical fitness proficiency testing in all schools.
- Urged the Medicaid Formulary Committee to include a wider variety of pain medication in the Medicaid formulary.
- Urged Obstetricians and Family

Physicians to encourage prenatal patients to meet with physicians and/or qualified personnel to receive education on breast feeding, preventive care, and care for newborn infants.

- Recommended that KMA members promote availability of the Rural Kentucky Scholarship Program and Establish Practice Grant Program to students and residents.
- Encouraged UK and U of L Medical Schools to develop a program addressing the risk to students of contracting Hepatitis B and implement a program for Hepatitis B vaccination for students.
- Discouraged insurance requirements to prescribe medication in large

quantities.

- Supported the development of ethical guidelines for physicians serving as consultants, administrators, witnesses, and in other business or judicial capacities not involved in direct patient care.
- Endorsed the study and evaluation of the need for public education or legislation relating to personal listening devices.
- Commended the AMA for its leadership in the fight to restore funding for RBRVS.

Over 2,000 registrants participated in the meeting which included over 1,100 physicians.

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**For Continued Support and  
Helping to Make the  
KMA 141st Annual Meeting  
a Success ---**

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## PEOPLE

**Salvatore J. Bertolone, MD**, a pediatric hematologist-oncologist at the University of Louisville School of Medicine and Kosair Children's Hospital, was among the winners of this year's Bell Awards, given to 10 Louisville area residents with extraordinary records of community service. The awards are made by the WLKY-TV Spirit of Louisville Foundation to recipients selected by a 34-member board of trustees from nominations from the community.

Dr Bertolone helped establish one of the first pediatric hospices in the country and worked to set up the local Ronald McDonald House and Louisville's chapter of the Dream Factory.

Hospice of Louisville has grown under Dr Bertolone's leadership as chairman of the board. He also serves on the medical advisory committee for the American Red Cross.

Two U of L professors are national newsmakers — pediatrics professor **J. Thomas Badgett, MD**, appeared on an ABC Evening News segment about Medicaid, and CBS News picked up an interview with psychiatry professor **Mohammad Shafii, MD**.

**Nelson B. Rue, Jr, MD**, was presented with the Service to Mankind Award given by the Kentucky Health Care Access Foundation, Inc, recently at its annual fund raiser, Twist And Bid Again.

In presenting the award before a record crowd of 550, foundation president, Lt Governor Brereton C. Jones said, "Dr Rue has continually demonstrated his dedication to the medical profession through his commitment to serving others. The foundation is most grateful to him for the leadership and support that he has given to it and its mission of providing quality health care to a



**K**MA's Kentucky Physicians Care Program continues to win recognition and awards. The most recent is the Associations Advance America Award from the American Society of Association Executives. The inscription reads, *For their outstanding program which has resulted in significant benefit to Society. As President Bush said in his challenge to associations, "There is no problem that is not being solved somewhere."*

In 1986, KPC was the recipient of a citation from President Ronald Reagan's President's Citation Program for Private Sector Initiatives for outstanding service to the community and finding innovative private solutions to public problems. In 1988, they received the American Medical Association President's Citation for Service to the Public. *KMA*

large number of Kentuckians. We are very fortunate that Dr Rue chose to support our efforts and we look forward to our continuing association with him."

The foundation is a nonprofit, private initiative, charitable, and educational organization that helps needy Kentuckians find access to quality health care.

Dr Rue, a Past President of KMA, is serving as vice president of the foundation.

## UPDATES

The James Graham Brown Cancer Center has been ranked number 42 in the top 100 cancer centers in the country.

In a recent *Coping Magazine*, the center was among a group that have become recognized regionally and nationally for their exceptional care and treatment of cancer patients. The evaluation team consisted of internationally recognized oncology physicians and researchers and the magazine's editors.

## NEW MEMBERS

*Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.*

### Breathitt

**Robert G. Cooper, MD** — S  
360 Kings Ridge Rd, Jackson 41339  
1977, U of Louisville

### Fayette

**Johannes C. Evans, MD** — OPH  
1401 Harrodsburg Rd, Lexington  
40504  
1986, U of Graz, Austria

**Robert S. Grover, MD** — PTH

PO Box 680, Lexington 40588  
1977, U of Utah

**William H. Leyva, MD** — D

807 Limestone, Lexington 40508  
1983, Loma Linda U

**Dale E. Toney, MD** — IM

3558 Creekwood Dr #23, Lexington  
40502  
1987, U of Kentucky

### Jefferson

**William P. Owen, Jr, MD** — P

PO Box 23617, Louisville 40223  
1978, U of Louisville

### Northern Kentucky

**David P. Thomson, MD** — EM

517 Canvasback Cir, Cincinnati 45246  
1987, U of Cincinnati

### Warren

**Pran M. Kar, MD** — NEP

201 Park St, Bowling Green 42102  
1983, U of Chicago

### New In-Training

#### Fayette

**Mark G. Delworth, MD** — U

**Afam C. Ikejiani, MD** — OBG

**Robert B. Matheny, Jr, MD** — PD

#### Jefferson

**Steven C. Eldenburg, MD** — FP

**Carolyn B. Gleason, MD** — IM

**Louis Todd House, MD** — AN

**A. Naweed Nasraty, MD** — IM

**William J. Schoen, MD** — IM

## DEATHS

**Sidney E. Isaacs, MD**  
Lexington  
1933-1991

Sidney E. Isaacs, MD, a retired anesthesiologist, died August 10, 1991. Dr Isaacs graduated from Boston University School of Medicine in 1960 and was a life member of KMA.

**Warren H. Proudfoot, MD**  
Morehead  
1921-1991

Warren H. Proudfoot, MD, a general surgeon, died August 31, 1991. A 1950 graduate of Harvard Medical School, Dr Proudfoot was a clinical professor of surgery at the University of Kentucky, president of Cave Run Clinic in Morehead, and chairman of the board of Markey Cancer Center in Lexington. He had also served as chairman of the Rowan County Board of Education since 1973. Dr Proudfoot was an active member of KMA.

**Garland R. Garst, MD**  
Glasgow  
1931-1991

Garland R. Garst, MD, a radiologist at T. J. Samson Community Hospital in Glasgow, died September 8, 1991. Dr Garst was a 1960 graduate of the University of Louisville School of Medicine and an active member of KMA.

**Elmer G. Prewitt, MD**  
Corbin  
1921-1991

Elmer G. Prewitt, MD, a retired family practitioner, died September 8, 1991. A 1955 graduate of the University of Louisville School of Medicine, Dr Prewitt was a life member of KMA.

**William R. Meeker, Jr, MD**  
Lexington  
1933-1991

William R. Meeker, Jr, MD, a surgeon, died September 19, 1991. He was president of the Kentucky Division of the American Cancer Society and a clinical professor at the University of Kentucky College of Medicine. A 1957 graduate of the Medical College of Alabama, Dr Meeker was an active member of KMA.



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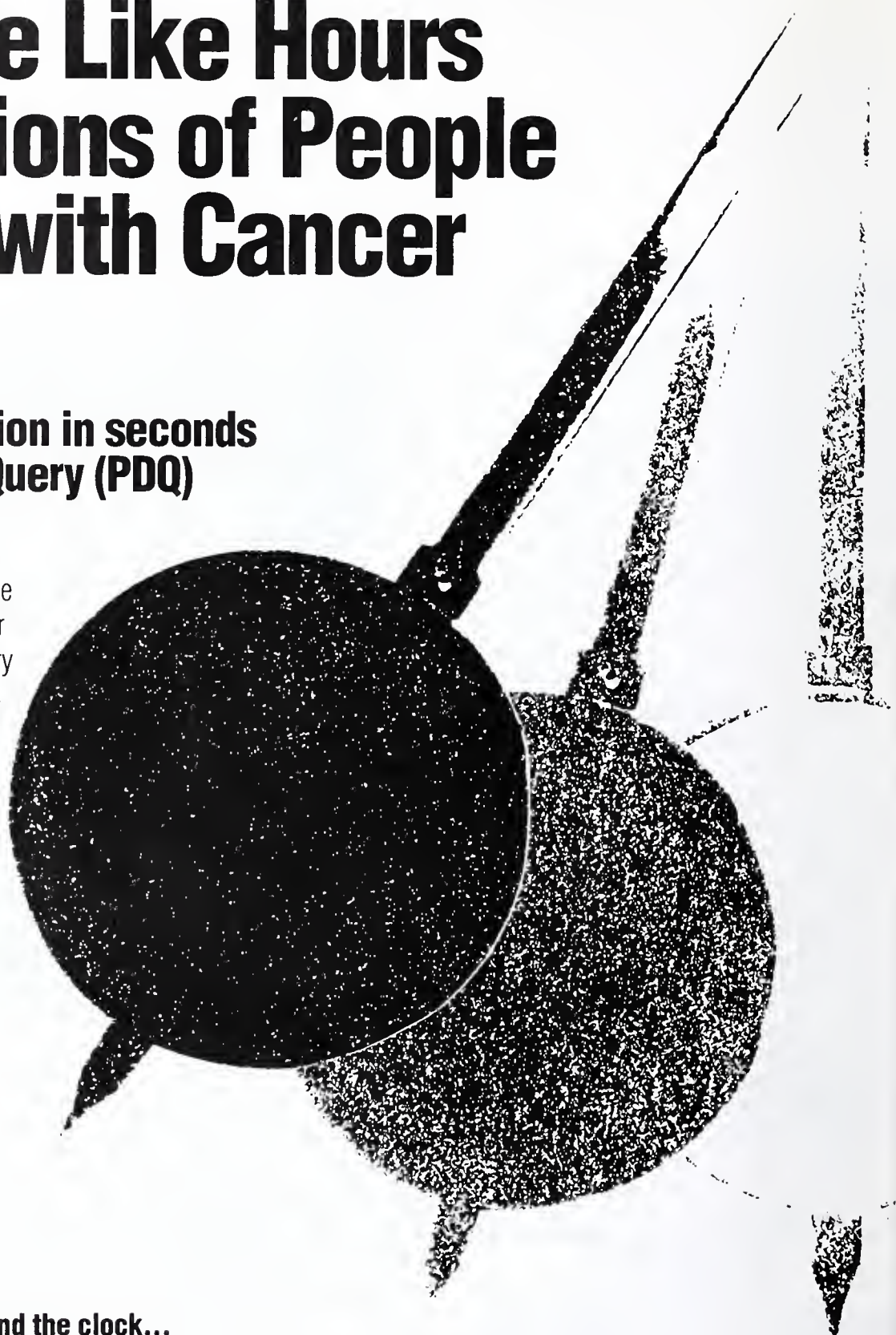
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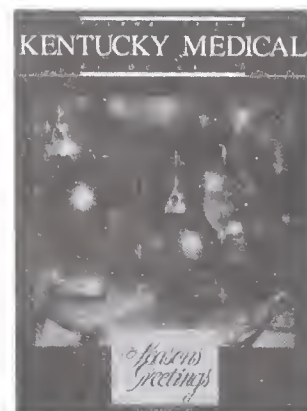


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ASSOCIATION

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DECEMBER 1991

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COVER: Cover illustration  
by Lee Wade.

This issue of the *Journal* provides extensive coverage of the 1991 KMA Annual Meeting, which was held September 30-October 4 in Lexington. An overview begins on page 602, with House of Delegates coverage beginning on page 619.

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## It Was A Good Year

**A**s this year comes rapidly to an end and we reflect back over the previous year, it is difficult to believe that the time has gone so quickly. 1991 has been another challenging year in medicine. Many issues have been addressed during the previous year, some old and some new. Certainly, health care coverage for our underinsured and uninsured, health care cost containment, the prevention of disease, quality care for our patients throughout their lives and the elderly in their final years, and our renewed dedication to professionalism in medicine are issues we must continue to address.

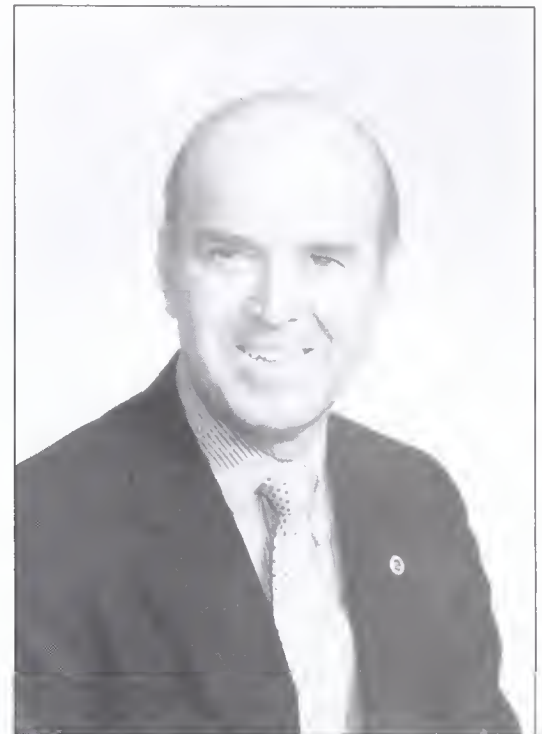
I feel that we have met the challenges and can be proud of our efforts this year. The enthusiastic response of physicians to the call for their support this year as we face the governmental changes with RBRVS indicates a strong renewal and awakening of physician concern throughout the country. While we can be proud of our accomplishments, we must realize there is still much work to be done in the coming year. There will again be many new issues and new challenges which we must face and resolve in the best interests of our physicians and our patients.

As you all know, we have a meeting of the State Legislature next year and there will probably be many new pieces of legislation introduced concerning health care. Our Legislative Committee will be following these bills closely and may need your help. I ask you to again respond positively, as you have in the past, when called upon for your support. Your help is crucial to their efforts.

Our Kentucky Medical Association is one we can look to with great pride. We must continue our dedication to help our organization grow better in numbers and in pride of achievement. Every good organization must have an excellent staff. We are fortunate, I feel, to be blessed with a superior staff of dedicated and hardworking people under the direction of Mr Robert Cox. I would be remiss in ending this report without thanking them and expressing my appreciation for all their work in the past year.

Finally, I would like to wish you and your families all the best for the Holiday Season and for the coming year.

**S. Randolph Scheen, MD**  
President




---

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# In Memoriam

*I do not think seventy years is the  
time of a man or woman, . . .  
Nor that years will stop the existence  
of me, or any one else.*

— WALT WHITMAN

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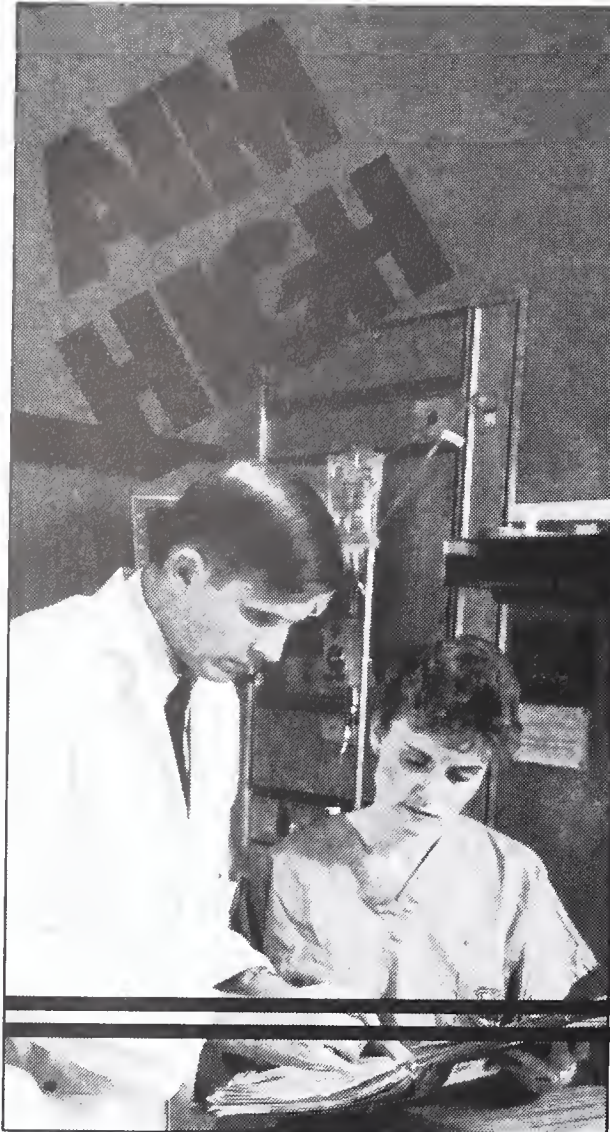
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# Kentucky Mental Illness Awareness Survey: Attitudes and Opinions

*Linda Burgess, MA; Leah J. Dickstein, MD; Knowlton Johnson, PhD; Thomas Lawson, PhD; Angela Lewis-Klein, MBA; Ellen van Nagell, MA*

## Introduction

For over 40 years, attitudes and knowledge about mental health have been surveyed. In the 1950s, the general public had a very isolated and misinformed view of mental health problems.<sup>1,2</sup> During the 1960s, attitudes and knowledge about mental health problems became more enlightened and factual.<sup>3,5</sup> In 1964, the Kentucky Mental Health Planning Commission conducted a seminal study<sup>6</sup> that included 985 respondents from across the state. The 1964 study sought to determine how "enlightened" Kentucky residents were about mental illness. Results indicated that most residents tended to be fairly knowledgeable with "enlightened" responses ranging from between 30% to 90%.

The 1989 Mental Illness Awareness Survey presented here was proposed by the Kentucky Psychiatric Association and does not replicate exactly the questionnaire of the 1960s. However, it did provide some insights as to the level of mental illness awareness that exists today in Kentucky. This survey focused on how Kentuckians define mental illness, their perceptions of its causes, their level of awareness about facts and fallacies of mental illness, and their opinions about a number of important mental illness issues. The survey findings are reported below. The 1989 survey also addressed attitudes and opinions of Kentucky residents relating to a variety of issues deemed important in developing mental illness programs and in setting policy.

## Procedure

Data for the present survey were collected by telephone interviews with 410 residents of Ken-

tucky. Responders were selected using computer generated lists of random telephone numbers representing all working exchanges in Kentucky. Interviews were conducted with adult household members selected by procedures which controlled for response bias related to sex and age of respondents. Calls were made over a 10-day period during the morning, afternoon, evening, and weekend hours in an attempt to reach as many eligible respondents as possible. At least five attempts were made to contact eligible respondents for each household in the sample. Interviews were conducted with respondents for 57 percent of the households determined to be eligible for participation in the survey. This response rate is comparable with those of other surveys using similar sampling procedures conducted by the Urban Research Institute. An overrepresentation of women in the sample (64%) as compared to the general population of Kentucky (51%)<sup>7</sup> was corrected in the analysis by using a poststratification weight to adjust all percentage distributions considered in this study.

A comparison of the survey respondents with the statewide population according to location (urban/rural), age, and education found the sample to be representative. Fifty-one percent of the survey respondents reported living in urban areas as compared to 52% of the statewide population.<sup>8</sup> Regarding the age distribution, 13% of the sample were 18 to 24, 21% were 25-34, 34% were 35 to 54, and 32% were 55 years or older. The percentage breakdown of the Kentucky population for these categories was 15%, 24%, 32%, and 29% respectively.<sup>7</sup> While there are no current published data available on the education distribution of the state population, it was found that the education distribution of the Kentucky sample (adjusted percentages) was comparable to that of a na-



## Kentucky Mental Illness Awareness Survey

tional sample (59,000) who responded to the 1987 annual population survey.<sup>9</sup> Thirteen percent of the Kentucky sample reported less than a ninth grade education as compared to 12% who responded to the national survey; 12% of the sample reported 9 to 11 years of education as compared to 16% of the national sample; and 38% and 37% of the sample, respectively, reported being high school graduates or attending/completing college as compared to 37% and 35%, respectively, of the national sample.

### Results

Table 1 presents respondents beliefs about which mental health problems should be considered mental illness. As can be seen from the percentages listed in Table 1, Kentucky residents usually identified schizophrenia (86%) and bipolar disorder (82%) as mental illnesses. Anxiety (69%) and depression (65%) were less frequently identified, but were still considered mental illness by a majority of Kentucky residents. Drug addiction (49%)

and alcoholism (46%) were the least recognized forms of mental illness. When the number of mental health problems listed in Table 1 considered as mental illnesses were analyzed by individual respondents, it was found that 16% of the respondents checked "yes" to only one or two of the problems listed (primarily schizophrenia and/or bipolar disorder). Forty-four percent of the respondents checked three or four problems (combinations of schizophrenia, bipolar disorder, anxiety, and depression), and 40% thought that five or six of the problems listed in Table 1 were forms of mental illness.

Kentucky residents appeared to have utilized a classic form mental illness categorization by singling out those disorders historically called psychotic disorders (schizophrenia and bipolar disorder) into one set, symptoms of mental disorders (anxiety and depression) into another set, and finally, abuse of substances (alcoholism and drugs) into the last set. Respondents who classified only the psychotic disorders as mental illnesses have a narrow or "restricted" view of mental illness, while those who classified not only the psychotic disorders, but also anxiety, depression, and substance abuse as mental illnesses have a broad or "inclusive" view of mental illness.

A close inspection of other results (not reported in table form) showed that the "restricted" and "inclusive" views were significantly related to demographic variables. For example, the "inclusive" view of mental illness was more likely to be taken by individuals who had more education, were from urban centers, were in the middle age groups (25-55 years), and who knew people who had sought treatment for mental illness. The "restricted" view of mental illness (only including traditional psychoses) was more likely to be used by people with less education, who lived in rural settings, were below the age of 25 years or over age 55 years, and who had not known a person who had sought treatment for a mental health problem. Thus, it appeared that the college students of the 1960s and 1970s had a much different view of mental illness than either their elders or young adults today.

Table 2 presents survey respondents' views about the causes of mental illness. The data in Table 2 demonstrate that survey respondents were more likely to consider physical than environmental factors as causes of mental illness. The previously developed categories of respondents (ie, "restricted" v "inclusive") were used to examine how Kentuckians selected causes for mental

**Table 1.** Mental Health Problems Considered as Mental Illness

Type of Mental Health Problem	Percent Agreeing
Psychotic Disorders	
Schizophrenia	86
Bipolar Disorders	82
Psychological Symptoms	
Anxiety	69
Depression	65
Substance Abuse	
Drug Addiction	49
Alcoholism	46

**Table 2.** Perceptions about the Causes of Mental Illness

Causes of Mental Illness	Percent Agreeing
Physical	
Chemical Imbalances in the Brain	93
Substance Abuse	86
Accidental Injuries	86
Heredity	75
Environmental	
Stress of Life	84
Bad Parenting	74
Weak Character	49

illness. A familiar pattern was found. Individuals with a broad or "inclusive" view of problems were more likely to exhibit an inclusive view of causes, stating that five of the six factors were causal conditions. Accidental injuries was the least likely to be chosen as a cause of mental illness by those holding an inclusive view. This is the previously discussed group who were more educated, between 25 and 55 years of age, and who were more likely to know someone who had suffered from mental illness. Respondents with the "restricted" view of mental illness also presented a "restricted" view of causes.

Responses to questions related to facts and fallacies (myths) about mental illness are displayed in Table 3. Kentucky residents overwhelmingly held very few false beliefs about mental illness. More than nine of ten (94%) stated that anyone can become mentally ill, and that children can suffer from mental illness. Eighty-two percent felt that people can return to productive lives following treatment for mental illness, and that not all persons with mental illness are violent. However, 18% of respondents still believe that people with mental illness are violent and cannot return to productive lives. The most widely held misperception about mental illness (71%) was that teenagers constitute the age group with the highest suicide rate (fallacy), while only 8% thought that the elderly had the highest suicide rate (fact). In fact, the suicide rate for elderly persons in Kentucky is approximately ten times higher than the teenage suicide rate.<sup>10</sup> The widely held belief that teens represent the greatest suicide risk clearly demonstrates the power of the media which in the past decade has greatly focused on teenage suicide, while largely ignoring suicide among the elderly, and has shaped public response.

While results of the present survey demonstrated that a vast majority of Kentucky residents did not hold false beliefs about mental illness, results also indicated that there exists an important segment of the population (between 7% and 23% depending on the fallacy or fact) who have incorrect information. Evaluation of related variables and results again revealed that age, education, and knowing an individual who sought treatment for a mental illness reduced belief in myths about mental illness.

Responses to questions about important issues related to mental health are contained in Table 4. Results indicated that health insurance coverage and finding affordable treatment for

mental illness are important issues to Kentucky residents. An overwhelming majority of the sample (94%) believed that there are attitudes associated with mental illness that are different from attitudes associated with physical illness, and a majority (69%) felt that people in Kentucky with a mental illness cannot find affordable treatment. It is important to note that a large portion of the sample (93%) believed that suitable housing is a necessary condition for the successful treatment of mental illness.

Kentuckians overwhelmingly supported (96%) the idea of health insurance that includes the same coverage for mental illness that it does for physical illness. Not only was there significant support for such a plan, a large majority (78%) also stated that mental health insurance coverage would critically influence their decision to seek treatment for a mental illness. Results also

**Table 3.** Responses to Facts and Fallacies about Mental Illness

Facts and Fallacies About Mental Illness		Percent Agreeing
FACT:	Anyone can become mentally ill	94
FACT:	Most people with serious mental illness can, with treatment, get well and return to productive lives	82
FACT:	The elderly have the highest suicide rate of any age group	8
FALLACY:	Teenagers have the highest suicide rate of any age group	71
FALLACY:	Almost all persons with mental illness are likely to be violent or dangerous	18
FALLACY:	Children do not suffer from mental illness	9

**Table 4.** Opinions about Important Issues of Mental Health

Mental Health Illness	Percent Agreeing
There are attitudes associated with mental illness that are different from attitudes associated with other physical diseases.	94
People with mental illness can easily find affordable treatment.	31
Suitable housing is a necessary part of effective treatment for persons with mental illness.	93
Health insurance should include same coverage for treatment of mental illness as for physical illness.	96
Mental health insurance coverage would influence my decision to seek treatment for a mental or emotional problem.	78
Everyone who has a mental illness should be placed in a mental hospital.	11
The trouble with most people who are mentally ill is that they just don't want to face their own problems.	39



## Kentucky Mental Illness Awareness Survey

showed that over one third (36%) of 88% of respondents who reported having health insurance did not know if their policy included coverage for treatment of mental illness.

Once again, education, age, and knowing a person who had sought treatment were important in shaping opinions about policy issues. Kentucky residents who were less educated, either under 25 or over 55 years of age, and who did not know someone with a mental illness tended to hold the opinion that there are no differences in attitudes toward mental illness, that people can afford treatment, and that health insurance or suitable housing were not necessary.

Two survey items were identical to items used in the 1964 Kentucky survey. One item (sixth item in Table 4) stated that "everyone who has a mental illness should be placed in a mental hospital." In the 1964 survey 41% agreed, and in the present survey only 11% agreed. The other item (last in Table 4) stated that "the trouble with most people who are mentally ill is that they just don't want to face their own problems." In 1964, 70% agreed; in 1989, only 39% agreed. These results depict a dramatic shift in attitudes about mental illness over the last two-and-a-half decades.

### Conclusions

Results of the present survey accurately reflected the views of the general public in Kentucky. While the majority of Kentucky residents possessed accurate information about mental illness, a disturbing percentage still was misinformed. This group, called "restricted" in the present study, was found to be primarily rural, less educated, and under 25 or over 55 years of age. Clearly, educational efforts should be targeted to this population.

In addition, more than nine of ten Kentuckians reported supporting health insurance that included mental health coverage. In fact, 78% stated that the presence or absence of benefits for mental illness would influence their decision to seek treatment. These two findings suggested that strong public opinion exists for insurance to cover treatment of mental illness.

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# Generic Medicine. Generic Insurance.

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***“In my brainstorm of great ideas, I felt that certain ‘high ticket’ items of medical care could be financed up front by adjusting the premium at the inception of the policy. . . .”***

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**“Y**es, but could we sell it?” That was the answer I got from an insurance agent who deals in actuary tables. I had asked him the possibility of selling a health insurance policy whereby the buyer selects from a “laundry list” of available coverage the type and extent of protection that he wants for himself and his family.

Most or all current policies deal with cost and type of hospital bed and what percent of charges will be covered. In my brainstorm of great ideas, I felt that certain “high ticket” items of medical care could be financed up front by adjusting the premium at the inception of the policy.

Costly medical care and procedures such as coronary artery bypass graft, organ transplant, severe third degree body burns, AIDS (HIV) therapy, metastatic cancer therapy, etc, could be figured on certain actuary tables. That cost could be added to the premium if chosen by the subscriber.

We know that most patients prefer generic medication because of the great savings made by their purchase. That same desire and savings can extend into the buying of cigarettes, canned goods, coffee, clothing, toiletry, and many other items sold but not promoted by advertising by the producers. Yet the patient does not want generic medical care at any level. He will want the same doctor continuity of care, private hospital rooms, excellent hospital food, and the most modern diagnostic and therapeutic measures. In other words, the very best.

MRI scans, CT scans, and cardiac

catheterization, and endoscopy are among the most expensive diagnostic measures. Cancer therapy that may entail surgery, radiation therapy, and chemotherapy is the most expensive of the common illnesses that we encounter.

The health insurance companies would write a basic policy for standard level of care. Then from the laundry list of expensive diagnostic procedures and costly therapy, an additional charge would be added to the premiums for each item chosen. The cost of each addition may vary from pennies to a few dollars, according to the age of the insurant and the actuary tables that give the odds of that particular person needing the procedure.

Wait you say! There is a flaw in my thinking. How does a man of 21 years know whether or not he will ever need bypass surgery or a kidney transplant? My answer is that that is what insurance is all about. Paying a small amount for something we hope never happens. Fire and theft insurance on our homes and cars have no value unless our valuables burn up or get stolen.

Wait you say! Your idea is fine for the wealthy, but how about the indigent and the poor? My answer is that they are not even now covered by any kind of insurance, so there would be no impact upon them either positively or negatively.

The above are just some random thoughts that may be pie-in-the-sky or an idea whose time has come. Can the insurance companies come up with the appropriate actuary tables? More importantly, could they sell it?

**Milton F. Miller, MD**



# CAGE Questionnaire

For the Diagnosis of Alcoholism

- C** = Have you ever felt you should **cut down** on your drinking?
- A** = Have people **annoyed** you by criticizing your drinking?
- G** = Have you ever felt bad or **guilty** about your drinking?
- E** = Have you ever had a drink first thing in the morning (**eyeopener**)?

---

Positive CAGE Answers:

1 = Suggestive 2 = Probable 3 and/or 4 = Diagnostic

---

**KENTUCKY MEDICAL ASSOCIATION**  
**Committee on Impaired Physicians**  
**301 N Hurstbourne Pky, Ste 200**  
**Louisville, KY 40222-8512**  
**(502) 426-6200**

## Information for Authors

**Manuscripts** — Articles will be accepted for consideration with the understanding that they are original and are contributed solely to this *Journal*. The transmittal letter should designate one author as correspondent and include the author's address and telephone number. Receipt of manuscripts will be acknowledged and unused manuscripts returned. All material is reviewed by the Board of Editors and publication of any article is not to be deemed an endorsement of the views expressed therein.

**Preparation** — Manuscripts should be typewritten in double spacing throughout, including references, tables, legends, quotations, and acknowledgments. Submit the original and one copy, retaining a copy for proofreading. Ordinarily articles should not exceed 3,000 words in length. Titles should include the words most suitable for indexing the article, should stress the main point, and should be short. A synopsis-abstract must accompany each manuscript. The synopsis should be a factual (not descriptive) summary of the work and should state the problem considered, methods, results and conclusions.

**Copyright assignment** — In view of The Copyright Revision Act of 1976, effective January 1, 1978, transmittal letters to the editor must contain the following language and must be signed by all authors: "In consideration of *The Journal of the Kentucky Medical Association* taking action in reviewing and editing my submission, the author(s) undersigned hereby transfers, assigns, or otherwise conveys all copyright ownership to *The Journal* in the event that such work is published by *The Journal*."

**References** — References must be typed in double spacing on separate sheets and numbered consecutively as they are cited. They should include (in this order) the authors' names and initials, title of article (and subtitle if any), abbreviated name of journal, year, volume number, inclusive page numbers. Follow the AMA style currently in use, abbreviating the names of journals in the form given in *Index Medicus*. Authors are responsible for reference accuracy.

**Illustrations** — Illustrations must be submitted in duplicate and the sequence number and author's name should appear on the back of each. Legends for illustrations should be typewritten (double-spaced) on a separate sheet. The author will be billed for the cost of reproduction of illustrated material for publication in excess of three average illustrations and/or tables. Illustrations other than the author's will not be accepted for publication unless accompanied by written permission from the original source.

**Editorials and Letters** — Should be written in clear, concise language. Length should be about two pages typed with double spacing. Letters will be published at the discretion of the Editorial Board.

**Reprints** — Reprints are available at an established schedule of costs. Order forms are sent to all authors at the time of publication.

# *Happy Holidays*

*From The  
Boards of*

*Kentucky Medical Association*

*And*

*Auxiliary Kentucky Medical Association*



*We Are Dedicated to the Medical Profession  
and the Future of Medicine  
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Within the last year, AKMA and the county auxiliaries raised \$71,580 for the American Medical Association Education and Research Foundation.

*These physicians and their spouses join together to insure  
the future of tomorrow's physicians in school today.*





# 141ST ANNUAL MEETING

*Clockwise: S. Randolph Scheen, MD, Louisville, took the oath to become KMA's 141st President. Board Chairman Cecil D. Martin, MD, Carrollton, presided over the installation.*

*President Scheen joined newly elected Vice President Ardis D. Hoven, MD, Lexington, and President-Elect William B. Monnig, MD, Edgewood, for a photo following the House of Delegates meeting.*

*It was a happy occasion when President Scheen received the first KMA Presidential Medallion. Dr Martin had the honor of presenting this Medallion which initiated a tradition that will be continued with future KMA Presidents.*







*Clockwise: Newly elected President Scheen and wife Betty shared an exciting Inauguration Day with former Presidents Preston Nunnelley, MD, his wife Lucille, and Nelson B. Rue, MD, and his wife Sue.*

*Leroy C. Hess, MD, received the Association's highest honor, the Distinguished Service Award. Awards Chairman Rue made the presentation.*

*Dr Ardis D. Hoven was recipient of the 1991 KMA Educational Achievement Award.*





### Inauguration

**S.** Randolph Scheen, MD, a Louisville dermatologist, was inaugurated 1991-92 President of KMA at the 141st Annual Meeting held in Lexington, September 30-October 3. Dr Scheen, a graduate of the University of Louisville School of Medicine, has served KMA as President-Elect, Secretary-Treasurer, and on numerous committees including Budget, Judicial Council, Committee on PLL, and as chairman of the Awards Committee for over 10 years.

### Elections

William B. Monnig, MD, an Edgewood urologist, was elected to the office of President-Elect of KMA. A graduate of

the University of Cincinnati, Dr Monnig's extensive service to KMA began in 1984 when he was elected 8th District Trustee, a position he held until 1990. He has served as Chairman of the Board of Trustees, Vice-President, Chairman of the Executive Committee of the Board of Trustees, as a member of the Quick Action Committee, and as Chair of the Building Committee. His commitment to KMA has been apparent through his many committee memberships, with current obligations to the State Legislative Committee, Committee on Medical Insurance, Physician-Attorney Liaison Committee, and Hospital Medical Staff Section.

Ardis D. Hoven, MD, Lexington infectious disease specialist, was elected to the office of Vice President. Dr Hoven is an Alternate Delegate to AMA and chairs the Committee on Community and Rural Health.

Two new Trustees were elected: Ronald E. Walldridge, MD, Shelbyville, 7th District, and Donald R. Stephens, MD, Cynthiana, 9th District. Reelected to 3-year terms were John W. McClellan, Jr, MD, Henderson, 2nd District Trustee; Russell L. Travis, MD, Lexington, 10th District Trustee; and Charles T. Watson, MD, Ashland, 13th District Trustee.

In other House elections, Donald C. Barton, MD, Corbin, and Harold L. Bushey, MD, Barbourville, were reelected AMA Delegates. J. Gregory Cooper, MD, Cynthiana, was elected as AMA Alternate Delegate and Donald J. Swikert, MD, Florence, was reelected AMA Alternate Delegate.

Board of Trustees elections included Russell L. Travis, MD, as Chairman of the KMA Board of Trustees, and Lucian Y. Moreman, II, MD, was reelected Vice-Chairman of the Board. Vice President Ardis D. Hoven and Board Chairman Russell L. Travis joined the KMA Executive Committee.

Five physicians were elected by the House of Delegates to serve on the 1991 Nominating Committee.



*Top: Dr Preston Nunneley delivered his exaugural address. Bottom: Past Presidents Wally O. Montgomery, MD (L), and Bob M. DeWeese, MD (R), escorted newly announced President-Elect William B. Monnig, MD, to the podium.*



Members elected were:

John D. Noonan, MD,  
Paducah, Chairman  
J. William Comer, MD  
Louisville  
Kenneth R. Hauswald, MD  
Ashland  
Dennis B. Kelly, MD  
Lexington  
G. Irene Minor, MD  
Berea

### President's Luncheon

A capacity crowd at the President's Luncheon honored outgoing President Preston P. Nunnelley, MD, and witnessed the installation of S. Randolph Scheen, MD, as the 141st President of KMA.

In his inaugural address, Dr Scheen emphasized the theme for the year, "Prevention: Rx for Health Care in the 90s." Notable comments included, "At the very core of controlling health care costs is the theme for this KMA year 'Prevention,' or as a television commercial on household furnaces states, 'Preventive Maintenance can really save you money' . . . Basic medical care should be available to every Kentuckian regardless of where they live. KMA needs to be at the forefront in this battle to prevent further erosion of rural care. . . . Medical care is a special responsibility which requires special people. There is no room in the health profession for impatient and uncaring people."

### DSA Award

The Association's most prestigious honor, the Distinguished Service Award, was presented to Leroy C. Hess, MD, an Erlanger family physician. Dr Hess was honored at the President's Luncheon for his long and distinguished service to the Association including the House of Delegates; Alternate Delegate to AMA; the Board of Trustees from 1966 to 1983; Chairman of the Board from

1969 to 1971; and President in 1972-73.

This was not the first Distinguished Service Award Dr Hess has received. In 1960 the Boone County Jaycees named him Man of the Year; in 1974 KPRO honored him with a DSA; and he has received two DSAs from Kentucky Blue Cross Blue Shield. Dr Hess was recognized not only for his tremendous contributions to organized medicine but also for exemplary service to his local community. It is noteworthy that he has been Chairman of the Boone County Board of Health since 1978; served on the Northern Kentucky Chamber of Commerce Board of Directors and was President in 1979. In addition, he has given freely of his time to local hospitals and county medical societies where he has held



*Top: Secretary-Treasurer William P. VonderHaar, MD, opened the House meeting. Bottom L to R: Delegates C. Milton Young, III, MD; Samuel G. Eubanks, Jr, MD; Ralph C. Morris, MD; and Beverly M. Gaines, MD, all of Louisville, enjoyed a light moment during a break in House action.*





*Left: AKMA Past President Betty Schrodt presented an AMA-ERF check to Emery A. Wilson, MD, Dean of the UK College of Medicine. Center: A capacity crowd attended the President's Luncheon. Bottom: President Nunnelley addressed the House. Seated L to R are Secretary-Treasurer William P. Vonderhaar, MD; KMA legal counsel Mike Cronan, JD; AKMA Past President Betty Schrodt; and House Speaker Danny M. Clark, MD.*



various offices. He has served the federation of medicine at every level from hospital staff to the American Medical Association.

In his presentation of the award to Dr Hess, Nelson B. Rue, MD, Chairman of the Awards Committee, concluded with these comments, "Few people have served more intensely or more honorably and few have devoted more time and energy to the causes of physicians than has our honoree. Over the years he and his family have endured several deep personal tragedies. Despite these tragedies, he remained steadfast by serving his community and, above all, his patients who are as devoted to him as he to them. Our honoree and his lovely wife, Wally, and their children, have certainly brought great credit to the medical community and, in particular, to this Association."

### **Lay Person Award**

The KMA Award, which is awarded to a lay person who has made significant contributions to the medical community, went to Carl L. Wedekind, Jr, of Louisville.

For many years following achievement of undergraduate and law degrees at the University of Virginia, Mr Wedekind practiced law in Louisville and served as general counsel to the Jefferson County Medical Society and the Kentucky Medical Association. In 1976, KMA was successful in obtaining the Kentucky General Assembly's support for legislation to relieve the malpractice crisis. One year later, the Kentucky Supreme Court found the

law unconstitutional. At that juncture, the KMA Board of Trustees chose not to return to the General Assembly but instead opted to form its own insurance company. The KMA Board of Trustees delegated the major responsibility of forming that company to Carl Wedekind. He worked diligently with the KMA Board and staff in establishing what proved to be an extremely successful

company. In 1981, the KMIC Board chose Wedekind as President and Chief Executive Officer, and he served in that capacity until his retirement this year.

Awards Chairman Rue included the following comments in his presentation. "Our 1991 recipient has been a close adviser and confidant to the KMA Board of Trustees and staff. His advice is valued and he has



*Right: Donald R. Kmetz, MD, Dean of the UofL School of Medicine accepted an AMA-ERF check from AKMA Past President Schrodt. Center: Carl L. Wedekind, Jr, JD, of Louisville (L) was recipient of the Lay Person Award. Awards Chairman Nelson Rue made the presentation. Bottom: L to R are Vice Speaker C. Kenneth Peters, MD; Board Chairman Cecil D. Martin, MD; outgoing President Preston P. Nunnelley, MD; newly elected President S. Randolph Scheen, MD; President-Elect William B. Monnig, MD; and Board Vice Chairman Lucian Y. Moreman, II, MD.*



the public at large, and members of the Kentucky General Assembly regarding the current AIDS epidemic over the past 3 years.

Beginning in 1987, Dr Hoven began giving extensive testimony to Committees of the state legislature which were considering mandatory AIDS testing for a number of groups. Through this testimony, major accomplishments were achieved in educating legislators and some onerous legislation was averted. She was then named to chair KMA's Ad Hoc Committee on AIDS. Under her chairmanship, a lengthy document was developed which was adopted by the House of Delegates as a policy statement on AIDS and was widely circulated to help physicians and the Legislature. Subsequently, Dr Hoven was elected as Chairperson of the KMA Committee on Community and Rural Health after the Ad Hoc Committee was disbanded, and this group now serves as an ongoing resource of AIDS information for the Legislature, physicians, and the public.

In addition to these efforts, Dr Hoven serves on the Lexington-Fayette County Board of Health and the Fayette County AIDS Crisis Task Force. She is widely sought by numerous organizations for advice and information.

President Preston P. Nunnelley, MD, in making the presentation recognized Dr Hoven's sacrificial contribution to education. "In spite of an extremely demanding clinical practice, our recipient has taken the time to educate us all by dispelling many myths and presenting us with the facts upon which to make rational

played an important role in the various activities of medicine. He is well respected in the liability insurance and legal fields and the growth of KMIC reflects his tremendous skills and intellect. He has authored many articles in the medico-legal field with a particular interest in a no-fault approach to resolving the malpractice crisis. It is a high personal privilege to present the

1991 KMA Award to Carl L. Wedekind, Jr."

### **Educational Achievement Award**

The recipient of the KMA Educational Achievement Award for 1990 was Ardis D. Hoven, MD, of Lexington. She achieved distinction for her accomplishments in educating physicians, allied health personnel,





*Left: AMA Alternate Delegate J. Gregory Cooper, MD, Cynthiana, entered the debate on the House of Delegates floor. Below: Mark F. Pelstring, MD, 8th District Trustee (second from left), discussed the issues with others from the Northern Kentucky constituency.*



decisions in our thinking and management of AIDS."

### **Auxiliary AMA-ERF**

During the first meeting of the House of Delegates, Betty Schrodtt, AKMA Past President, presented AMA-ERF checks to the two medical schools on behalf of the Auxiliary. Since 1950, the AMA-ERF has continually been supportive of quality medical education, with contributions now exceeding \$2 million annually. The extraordinary fund raising effort of the AMA Auxiliary and the generosity of contributing medical families and private enterprise continue to secure AMA-ERF as a viable support for medical education.

In Kentucky, AMA-ERF funds are given proportionally to the two medical schools as designated by the donors. Dr Donald R. Kmetz, Dean of the University of Louisville School of Medicine, accepted a check from Mrs Schrodtt for \$34,058.15, and Dr Emery A. Wilson, Dean of the University of Kentucky College of Medicine, accepted a check for \$19,608.86.

### **Fifty-Year Members**

Those KMA member physicians who

have been practicing medicine for 50 years or more were recognized during the President's Luncheon. Achieving that status this year are: Drs Norman Adair, Hugh P. Adkins, Robert J. Alberhasky, Frank M. Alfano, John H. Burke, Fernando P. Fornaris, Frank M. Gaines, Jr, Elmer A. Gearhart, Logan Gragg, C. Noel Hall, Edwin L. Higgins, Vester Aubrey Jackson, Robert Bryant Jasper, Martin Z. Kaplan, John S. Llewellyn, Thomas M. Marshall, Wyatt Norvell, Herbert T. Ransdell, Jr, George C. Reed, Frederick R. Scroggin, Robert D. Shepard, Martha J. Stewart, Jesse L. Walker, Richard H. Weddle, and George P. Whiteside.

### **In Memoriam**

During the first House of Delegates meeting, Dr William P. VonderHaar requested that the audience stand for a moment of silence in memory of those physician members who had died in the last year. A list of deceased appears on page 593 of this *Journal*.

### **KMA-MSS and RPS**

The KMA Medical Student Section and Resident Physicians Section met, for the first time, in a joint session

during KMA's Annual Meeting on October 3. Over 175 medical students and residents participated in the meeting which was highlighted by a presentation on "Resident Work Hours" by Ward O. Griffen, MD, Executive Director of the American Board of Surgery. Presenting AMA's position on this issue was William Johnstone, MD, Greenville, NC, AMA-RPS Secretary-Treasurer.

An up-to-date report on several major national legislative issues affecting the future practice of medicine was presented by Sharon Swan, Policy Analyst for the AMA Department of Medical Student Services.

### **KEMPAC**

The 29th KEMPAC Seminar Banquet was held during this year's Annual Meeting on Monday, September 30, at the Hyatt Regency Hotel, Lexington. A large audience of physicians, spouses, Kentucky State Representatives, Senators, and their staff were addressed by gubernatorial candidates Congressman Larry Hopkins and Lieutenant Governor Brereton Jones. Neal Rhoades, JD, AMPAC Regional Political Director,



*Below: Newly elected 7th District Trustee Ronald E. Waldrige, MD, Shelbyville, and outgoing Board Chairman Martin, Carrollton (both seated right of table), held a meeting with members of their District. Right, top to bottom: Gubernatorial candidates Brereton Jones and Larry Hopkins spoke at the KEMPAC dinner. Neal Rhoades, JD, AMPAC Regional Political Director, Washington, DC, and KEMPAC Chairman David B. Stevens, MD, Lexington, also addressed the assembly.*



Washington, DC, brought greetings from the national office. David B. Stevens, MD, Lexington, outgoing KEMPAC Chairman, presided at the meeting.

**House Action Summary**

The 1991 KMA House of Delegates adjourned on October 2, 1991. Highlights of actions taken are listed below. Please refer to the House of Delegates section in this *Journal* for a complete text of the Committee Reports and Resolutions.

- Gave KMA Board of Trustees authority to restructure KMIC ownership so that a holding company can be established providing KMIC flexibility to become a part of a larger group of companies, should that be desirable.
- Approved continuation of the Kentucky Physicians Care Program.
- Established guidelines for specialty groups participating in the KMA Annual Meeting.
- Recommended that CHR provide a video tape to physicians offices on Breast Cancer Options.
- Approved recommendation that KMA support legislation to ban all fireworks except professional displays.

- Directed KMA to seek resolution to the issue of hospitalization or denying nursing home admission for MRSA-diagnosed patients.
- Expressed appreciation to the Kentucky Department for Health Services and the leadership of Reginald Finger, MD.
- Adopted guidelines on HIV testing for physicians and HIV-infected physicians.
- Urged the Kentucky General Assembly to prohibit students in grades 7-8 from participating in varsity soccer, football, and wrestling.
- Adopted position opposing corporal punishment in schools.
- Recognized patriotism of medical personnel serving in Operation Desert Storm.
- Encouraged hospital medical staffs to choose representatives and actively participate in the KMA Hospital Medical Staff Section.
- Directed KMA to evaluate other states that allow only physicians to credential physicians; alert members of economic credentialing and its effect on physicians' practices; and joined AMA in opposing economic credentialing.
- Directed KMA to develop model medical staff bylaws and/or guidelines







*Top: Mary L. Wiss, MD, Pikeville, and Samuel D. Weakley, MD, Louisville, represented their Districts as Delegates. Center L to R: Delegate John D. Cronin, Lexington, shared thoughts on the issues with newly elected 9th District Trustee Don R. Stephens, MD, Cynthiana, and outgoing 9th District Trustee Kelly G. Moss, MD, Maysville.*



*Included in the Louisville Delegation were Martha T. McCoy, MD (L), and Linda H. Gleis, MD.*

suitable for Kentucky and make them available to hospital medical staffs upon request for an appropriate fee.

- Endorsed legislation opposing the use of billboards or other mediums which advertise tobacco products visible from school property (K-12); restricting tobacco vending machine use to persons 18 years or older; mandating local health departments to provide smoking cessation clinics to children under 18 in areas where similar classes are not available.
- Encouraged KMA to work with the State Department of Health to disseminate radon guides to physicians and other appropriate information on other health hazards to educate patients and work to standardize and measure reporting of radon levels.
- Complimented KMA's Legislative Committee for efforts in assisting AMA's campaign to block HCFA's rejection of the RBRVS agreement.
- Recommended KMA support efforts to develop a separate Impaired Physicians Committee Office with a full-time Medical Director.
- Opposed any new legislation or proposal permitting nonphysicians to perform laser surgery.
- Urged the federal government to overturn Medicare fee discrimination against new physicians and to treat all physicians fairly.
- Directed that DNR orders in the prehospital setting be developed and incorporated into state statutes.
- Opposed publication of rape victims names.
- Opposed gag rules in pregnancy options counseling or any other similar intrusion into the doctor/patient relationship.
- Directed KMA to assume a leadership role in a task force on health costs and problems facing the current health care system in Kentucky.
- Voted to exclude Kentucky's participation in the Medicare select policy program and urged that HMOs





*Top: Journal Scientific Editor Daniel W. Varga, MD (center), is seated with fellow Louisville Delegates, L to R, David E. Bybee, MD; Lynn T. Simon, MD; Robert Couch, MD (behind Dr Varga); and John Jurige, Jr, MD. Center L to R: Delegate Earl P. Oliver, MD, Scottsville, is seated with 6th District Trustee Jerry W. Martin, MD, and Delegates Jane R. Bramham, MD, and Paul J. Parks, MD, all of Bowling Green.*



*L to R: Alternate Delegate Charles R. Dodds, MD, Earlington, relaxed during a break with Delegates William H. Klompus, MD, Madisonville, and James E. Redmon, Jr, MD, Louisville.*

conform to Medicare supplement guidelines as originally developed by the National Association of Insurance Commissioners.

- Recommended that KMA develop close communication with the Kentucky PRO to help settle disputes and work to achieve local meetings between the PRO and physicians on a regular basis.

- Directed KMA to continue to seek budget neutrality in regards to RBRVS as originally proposed and agreed.

- Endorsed the concept that Kentucky be treated as a one-fee area.

- Took action to encourage uniform health education and physical fitness proficiency testing in all schools.

- Urged the Medicaid Formulary Committee to include a wider variety of pain medication in the Medicaid formulary.

- Urged Obstetricians and Family Physicians to encourage prenatal patients to meet with physicians and/or qualified personnel to receive education on breast feeding, preventive care, and care for newborn infants.

- Recommended that KMA members promote availability of the Rural Kentucky Scholarship Program and Establish Practice Grant Program to students and residents.

- Encouraged UK and U of L Medical Schools to develop a program addressing the risk to students of contracting Hepatitis B and implement a program for Hepatitis B vaccination for students.

- Discouraged insurance requirements to prescribe medication in large quantities.

- Supported the development of ethical guidelines for physicians serving as consultants, administrators, witnesses, and in other business or judicial capacities not involved in direct patient care.

- Endorsed the study and evaluation of the need for public education or legislation relating to personal listening devices.





*James R. Pigg, MD (L), 14th District Trustee, Pikeville, chats with 4th District Trustee Lucian Y. Moreman, II, MD, Elizabethtown.*



- Commended the AMA for its leadership in the fight to restore funding for RBRVS.

### Attendance

The Annual Meeting continued its increased attendance with a total registration of 2,090, surpassing by more than 200 the attendance at the 1988 meeting held in Lexington. Physicians numbered 950 and medical students 250, resulting in a very successful 141st KMA Annual Meeting at the Hyatt Regency Hotel/Lexington Center in downtown Lexington.

The 1992 Annual Meeting will be held in Louisville. The Board of Trustees has selected the very accommodating and spacious Hyatt Regency Hotel/Commonwealth Convention Center in downtown Louisville to house the meeting. Over 22 specialty groups and an estimated 2600 registrants are expected to attend.

Please mark your calendars to attend the 1992 Annual Meeting to be held September 13-17.

KVA



*Top: Ward O. Griffen, MD, Executive Director of the American Board of Surgery (left), and William Johnstone, MD, AMA-RPS Secretary-Treasurer, addressed the KMA-MSS and RPS meeting. Center L to R: Delegate Mary P. Fox, MD, of Pikeville, had a discussion with Louisville Delegates Barry Wainscott, MD, and David T. Allen, MD. Bottom L to R: Lexington Delegates representing the 10th District were Andy M. Moore, II, MD; John D. Stewart, MD; John R. White, MD; and John R. Allen, MD.*



# Silence Is Not Golden

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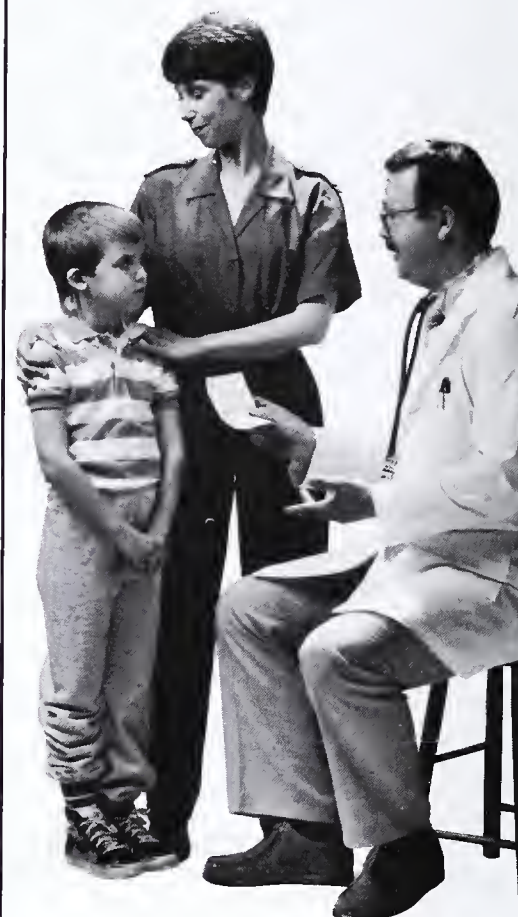
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Washington, DC 20001

# Letters From Annual Meeting Guests

October 4, 1991

William T. Applegate  
Deputy Executive Vice President  
Kentucky Medical Association

Dear Bill:

Sorry I did not get to meet you at the time of the 141st Annual Meeting of the Kentucky Medical Association but I can tell you I was most impressed. The breadth of the program was striking and the quality of the presentations I heard was most unusual. I think this was an excellent meeting that the Kentucky Medical Association should be very proud of. It was clear that there was a tremendous amount of interest and I congratulate both you and Dr Nunnelley on this very successful meeting and Association.

Beth Thomas was very helpful to me at the time of my presentation and I also enjoyed participating in the American College of Surgeons program in the afternoon.

Again I thank the Kentucky Medical Association for a very pleasant experience.

Sincerely,  
Walter Lawrence, Jr, MD  
Division of Surgical Oncology  
Medical College of Virginia

---

October 7, 1991

William T. Applegate  
Executive Vice President  
Louisville, KY 40222

Dear Mr Applegate:

I very much enjoyed having taken part in the recent meeting of the Kentucky Medical Association. It is always a privilege to have the opportunity to communicate with medical colleagues.

It was an honor to have been introduced by Dr William Monnig, KMA's Vice President. I also would like to ask you to convey my appreciation to Ms Sue Tharp for her assistance in my presentation.

Sincerely yours,  
George W. Weinstein, MD  
President  
American Academy of Ophthalmology

---

October 2, 1991

William T. Applegate

Dear Bill,

I enjoyed my trip to the KMA meeting. It was excellent and well organized. Thanks for asking me.

Sincerely,  
Bob Park, MD  
Department of the Army  
Walter Reed Army Medical Center



# Was Your Delegate Present?

## ROLL CALL

### 1991 House of Delegates

### KMA Annual Meeting

## OFFICERS

		First Meeting	Second Meeting
Speaker	Danny M. Clark	Present	Present
Vice Speaker	C. Kenneth Peters	Present	Present
President	Preston P. Nunnolley	Present	Present
President-Elect	S. Randolph Scheen	Present	Present
Vice-President	William B. Mannig	Present	Present
Secretary-Treasurer	William P. VonderHaar	Present	Present
Delegate to the AMA	Donald C. Barton	Present	Present
Delegate to the AMA	Harold L. Bushey	Present	Present
Delegate to the AMA	Robert R. Goodin	Present	Present
Delegate to the AMA	Wally O. Montgomery	Present	Present
Alternate Delegate to the AMA	Bob M. DeWeese	Present	Present
Alternate Delegate to the AMA	Larry C. Franks	Present	Present
Alternate Delegate to the AMA	Ardis D. Hoven	Present	Present
Alternate Delegate to the AMA	Donald J. Swikert	Present	Present

## TRUSTEES

District			
First	Robert P. Meriwether	Present	Present
Second	John W. McClellan, Jr	Present	Present
Third	William L. Miller	Present	Present
Fourth	Lucian Y. Moreman, II	Present	Present
Fifth	Joseph E. Kutz	Present	Present
Sixth	Jerry W. Martin	Present	Present
Seventh	Cecil D. Martin	Present	Present
Eighth	Mark F. Pelstring	Present	Present
Ninth	Kelly G. Moss	Present	Present
Tenth	Russell L. Travis	Present	Present
Eleventh	William H. Mitchell	Present	Present
Twelfth	David C. Liebschutz	Present	Present
Thirteenth	Charles T. Watson	Present	Present
Fourteenth	James R. Pigg	Present	Present
Fifteenth	Paul R. Smith	Present	Present

## ALTERNATE TRUSTEES

District			
First	Dan M. Miller	Present	Present
Second	Christopher R. McCoy	Present	Present
Third	Charles R. Dodds	Present	Present
Fourth	Salem M. George	Present	Present
Fifth	Larry J. Wilson	Present	Present
Sixth	John D. Gover	Present	Present
Seventh	William P. McElwain	Present	Present
Eighth	Jahn D. Ammon	Present	Present
Ninth	Don R. Stephens	Present	Present
Tenth	Thomas K. Slabaugh	Present	Present
Eleventh	G. Irene Minor	Present	Present
Twelfth	Scott B. Scutchfield	Present	Present
Thirteenth	Bruce M. Stapleton	Present	Present
Fourteenth	Nicholas R. Jurich	Present	Present
Fifteenth	Rogelio A. Acosta	Present	Present

## PAST PRESIDENTS

Past President	Nelson B. Rue	Present	Present
Past President	Bob M. DeWeese	Present	Present
Past President	Donald C. Barton	Present	Present
Past President	Richard F. Hench	Present	Present
Past President	Wally O. Montgomery	Present	Present

DELEGATES  
FIRST DISTRICT

		First Meeting	Second Meeting
BALLARD CALLOWAY	R. Gary Marquardt Dan Miller	Present Present	Present Present
CARLISLE FULTON GRAVES	Robert D. Fields Charles D. LeNeave Bruce C. Smith Stephen Burkhart H. W. Ford Harry Carlross Keith H. Crawford Stephanie R. Hatfield David Andrew Meyer John D. Noonan Ben H. Taylor	Present Present Present Present Present Present Present Present Present Present Present Present	Present Present Present Present Present Present Present Present Present Present Present Present

## SECOND DISTRICT

DAVISS	John T. Houston John D. Jefferies Ronald M. Johnson Christopher R. McCoy R. J. Phillips, Jr Robert L. Reid Thomas M. Gadiant Frank K. Sewell, Jr Rogelio A. Silva Wallas N. Bell	Present Present Present Present Present Present Present Present Present Present	Present Present Present Present Present Present Present Present Present Present
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## THIRD DISTRICT

CALDWELL CHRISTIAN	Nathaniel H. Talley Emmanuel J. Battah Don Lavie Perkins Kelly S. Tate Scott R. Graham Wallace R. Alexander William H. Klompus Tristan K. Lineberry Rodger J. Zwemer, Jr Steve Hiland Aubrey L. Armstrong Hank Bell, Jr	Present Present Present Present Present Present Present Present Present Present Present Present Present	Present Present Present Present Present Present Present Present Present Present Present Present Present
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## FOURTH DISTRICT

BRECKINRIDGE BULLITT GRAYSON GREEN HARDIN-LARUE	James R. Cundiff, Jr Ray A. Cave Kenneth J. DeSimone Nga T. Nguyen Collard Marion A. Douglass, Jr James T. Engle, Jr Lovegildo Garcia William C. Nash Kevin L. Flowers John W. Ratliff Raymond L. Mathis	Present Present Present Present Present Present Present Present Present Present Present Present	Present Present Present Present Present Present Present Present Present Present Present Present
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HART  
MARION  
MEADE  
NELSON

TAYLOR  
WASHINGTON

Eugene H. Shively Present Present  
Suk K. Kah .....

## FIFTH DISTRICT

JEFFERSON

David T. Allen Present Present  
Susan M. Berberich ..... Present  
David H. Bizat ..... Present  
Dwight L. Blackburn Present .....  
Harold W. Blevins ..... Present  
Philip T. Brawne .....  
William C. ..... Present  
Buschemeyer, Jr .....  
David E. Bybee ..... Present  
Peter C. Campbell Present Present  
Stuart P. Cohen .....  
J. William Camer Present Present  
Robert H. Cauch ..... Present  
Robert Craig DeWeese .....  
John H. Dayle Present Present  
Rudy J. Ellis, Jr ..... Present  
Samuel G. Eubanks, Jr Present Present  
Mary E. Fallat ..... Present  
John M. Farmer .....  
Larry D. Flarman .....  
Beverly M. Gaines ..... Present  
Henry D. Garretsan .....  
Katherine P. Garrison ..... Present  
Darius Ghazi ..... Present  
Linda H. Gleis ..... Present  
Harold D. Haller Present Present  
B. Thomas Harter, Jr .....  
Juliana Hayden .....  
Walter I. Hume, Jr ..... Present  
Clifford V. Jennings .....  
John Jurige, Jr ..... Present  
John M. Kariba ..... Present  
Arthur H. Keeney .....  
Virginia T. Keeney ..... Present  
Donald R. Kmetz Present Present  
Robert W. Linker, III .....  
Martha T. McCay ..... Present  
Garden T. McMurry ..... Present  
Robert L. McQuady, Jr .....  
Frank B. Miller ..... Present  
Ralph C. Marris ..... Present  
Marris Nacke ..... Present  
Syed M. Nawab .....  
Catherine Newton ..... Present  
Robert L. Nald ..... Present  
James E. Redman Present Present  
K. Thomas Reichard Present Present  
Steven J. Reiss ..... Present  
William M. Renda .....  
George Randolph Schradt ..... Present  
Robert F. Sexton, Jr Present Present  
Kerry L. Shart .....  
Lynn T. Siman ..... Present  
C. Steven Smith .....  
William C. Templeton, III ..... Present  
Rebecca A. Terry .....  
Daniel W. Varga ..... Present  
Barry L. Wainscott ..... Present  
David R. Watkins Present Present  
Thomas R. Watson .....  
Peter H. Wayne, III .....  
Samuel D. Weakley Present Present  
A. Franklin White, Jr ..... Present  
Fred A. Williams, Jr ..... Present  
C. Milton Young, III Present Present

## SIXTH DISTRICT

ADAIR  
ALLEN  
BARREN  
BUTLER  
CUMBERLAND  
EDMONSON  
LOGAN  
METCALFE  
MONROE  
SIMPSON  
WARREN  
Jesus Siady .....  
Earl P. Oliver Present Present  
Ray A. Gibsan .....  
Marris David Mass .....  
Richard T. Wan ..... Present  
Omkar N. Bhatt .....  
Lawrence P. Embertan .....  
James E. Carter .....  
Michael Pulliam Present Present  
Craig Alvin Beard ..... Present  
Jane R. Bramham Present Present  
John E. Dawning ..... Present  
Paul J. Parks Present Present

## SEVENTH DISTRICT

ANDERSON  
CARROLL  
FRANKLIN  
GALLATIN  
GRANT  
HENRY  
OLDHAM  
OWEN  
SHELBY  
M. Braks Jackson, II ..... Present  
Ronald Waldrige Present Present  
David W. Wallace .....  
William K. Skaggs .....  
Raderick H. MacGregar Present Present  
Michael L. Rabinsan Present Present  
Charles L. Stephens .....  
Frederick A. Stine Present Present  
Steven M. Waadruff Present Present  
Gardan W. Air Present Present  
John Franklin Allnut Present Present  
Elbert D. Baldridge, Jr Present Present  
Thames E. Bunnell Present Present  
Harry W. Carter Present Present  
James H. Linne .....  
Joseph C. Martin ..... Present  
Theodore H. Miller Present Present  
Jackson O. Pemberton Present Present  
B. Robert Schwartz ..... Present  
SPENCER  
TRIMBLE  
BOONE  
CAMPBELL  
KENTON

## NINTH DISTRICT

BATH  
BOURBON  
BRACKEN  
FLEMING  
HARRISON  
MASON  
NICHOLAS  
PENDLETON  
ROBERTSON  
SCOTT  
Glenn R. Wamack .....  
Greg Caaper ..... Present  
Donald R. Stephens Present .....  
Wendell R. Kingsalver .....  
Robert L. McKenney Present Present  
James C. Cantrill Present Present

## TENTH DISTRICT

FAYETTE  
John R. Allen Present Present  
James W. Baker Present Present  
Ralph D. Caldraney Present Present  
John W. Callins Present Present



Max A. Crocker	Present	Present
John D. Cranin	Present	Present
Elvis S. Donaldson, Jr	.....	Present
Harald T. Faulconer	Present	Present
John M. Fox	Present	Present
Bill H. Harris	Present	Present
Dennis B. Kelly	Present	Present
Daniel E. Kenady, Sr	Present	Present
John L. Kiesel	Present	Present
William D. Medina	Present	Present
Andrew M. Moore, II	Present	Present
Franklin B. Maasnick	Present	Present
Barbara A. Phillips	Present	Present
John W. Poundstone	Present	Present
Andrew R. Pulito	Present	Present
Barry N. Purdom	.....	.....
Thomas K. Slabough	Present	Present
John D. Stewart	Present	Present
Gary R. Wallace	Present	Present
John Robert White	Present	Present
Emery A. Wilson	Present	Present

JESSAMINE  
WOODFORD

# ELEVENTH DISTRICT

John A. Patterson	.....	.....
James B. Noble	.....	.....
G. Irene Minor	Present	Present
Richard A. Stone	Present	Present

Mary Louise Pratt	.....	.....
Paul F. Maddox	.....	Present

# TWELFTH DISTRICT

David C. Liebschutz	Present	Present
Scott B. Scutchfield	Present	Present
Lewis E. Wesley	Present	Present

Paul J. Sides	.....	Present
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Nick G. Dedman	Present	.....
Danald E. Brown	Present	Present
James D. Crase	Present	Present
Joseph G. Weigel	Present	Present

ROCKCASTLE  
RUSSELL  
WAYNE

H. Michael Oghia	Present	Present
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# THIRTEENTH DISTRICT

BOYD	Kenneth R. Hauswald	Present	Present
	Howard B. McWhorter	Present	Present
	John R. Potter	Present	Present
	Susan H. Prasher	.....	Present

CARTER  
ELLIOTT  
GREENUP

Manuel S. Garcia	.....	Present
John O. Jones	Present	.....
George P. Carter	Present	Present

LAWRENCE  
LEWIS  
MORGAN  
ROWAN

Marc L. Holbrook	Present	Present
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# FOURTEENTH DISTRICT

BREATHITT	Gangadhar L. Maddiwar	.....	Present
FLOYD	Diane E. Shafer	Present	.....
JOHNSON			
KNOTT			
LETCHER	Artie A. Bates	.....	.....
MAGOFFIN			
MARTIN			
PERRY	Mitchell Wicker, Jr	.....	.....
PIKE	Mary Pauline Fox	.....	Present

Raghuram S. Modur	Present	.....
Elster D. Roberts	Present	Present
Mary L. Wiss	Present	Present

# FIFTEENTH DISTRICT

BELL	Meredith J. Evans	.....	Present
CLAY	Ira F. Wheeler	.....	Present
HARLAN	Rachel R. Eubank	Present	Present
	James K. Hurlocker	Present	Present
KNOX	Rogelio A. Acosta	Present	Present
LAUREL	David W. Douglas	Present	Present
LESLIE			
WHITLEY	Frank H. Catron	Present	Present
	Jagdish S. Patil	.....	Present
	Carmel Wallace, Jr	.....	.....

KMA Resident Physicians Section—Mark G. Delwarth	Present	Present
U of K Student Delegate—Matthew Shotwell	.....	.....
U of L Student Delegate—Daniel Wilds	.....	Present
KMA-HMSS—William D. Pratt	Present	Present

The information in the Roll Call was taken from the attendance record cards signed by the delegates prior to the meetings of the House, September 30 and October 2.



# ***PROCEEDINGS***

## **141st Annual Meeting Kentucky Medical Association**

**September 30-October 3, 1991**



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(L to R) Reference Committee 1: Howard McWorter, MD, Ashland; H. Michael Oghia, MD, Russell Springs; Ralph D. Caldrony, MD, Lexington, Chairman; Jane Bramham, MD, Bowling Green; Donald Brown, MD, Somerset.



Reference Committee 2: R. Gary Marquardt, MD, Murray; Harry W. Carter, MD, Ft. Mitchell, Chairman; Susan H. Prasher, MD, Ashland; Samuel G. Eubanks, MD, Louisville; James T. Engle, Jr, MD, Elizabethtown.



Reference Committee 3: Beverly M. Gaines, MD, Louisville; Keith H. Crawford, MD, Paducah; Rachel R. Eubank, MD, Harlan; Thomas K. Slabaugh, MD, Lexington; Scott B. Scutchfield, MD, Danville, Chairman.



Reference Committee 4: G. Irene Minor, MD, Berea; William H. Keller, MD, Frankfort; K. Thomas Reichard, MD, Louisville; Gordon W. Air, MD, Crestview Hills; Andrew R. Pulito, MD, Lexington, Chairman.



Reference Committee 5: William M. Renda, MD, Louisville; Frank K. Sewell, MD, Henderson; Frank H. Catron, MD, Corbin, Chairman; Ronald E. Waldrige, MD, Shelbyville; Gary R. Wallace, MD, Lexington.



Reference Committee 6: Peter C. Campbell, MD, Louisville; Nick G. Dedman, MD, Harrodsburg; John W. Collings, MD, Lexington, Chairman; Bob M. DeWeese, MD, Louisville; Matthew Shotwell, (MSS), Lexington.

# The James Given Carpenter, MD Memorial Meeting of the Kentucky Medical Association

*\*Digest of Proceedings of the Regular Session of the  
House of Delegates*

**Danny M. Clark, MD, Somerset  
Speaker of the House, Presiding**

## **First Meeting September 29, 1991**

**D**anny M. Clark, MD, Speaker of the KMA House of Delegates, called the first meeting of the 141st Session of House of Delegates to order at 9:00 AM on Monday, September 29, 1991, at the Hyatt Regency Hotel, Lexington, Kentucky. He introduced the Vice Speaker, C. Kenneth Peters, MD, Jeffersontown, and KMA's Legal Counsel, Charles J. Cronan, IV, Louisville.

Following the invocation given by Paul J. Parks, MD, Bowling Green, the Chairman of the Credentials Committee, Peter C. Campbell, Jr, MD, Louisville, reported that a quorum was present. It was noted Paul J. Sides, MD, Lancaster, and David R. Watkins, MD, Louisville, also served on the Credentials Committee.

A motion was made, seconded, and carried to approve the Minutes of the 1990 Session of the House of Delegates as published in the December 1990 *Journal of the Kentucky Medical Association*.

William P. VonderHaar, MD, Louisville, Secretary-Treasurer, announced that the Scientific Session would begin at 8:50 AM on Tuesday, October 1, and the President's Luncheon would be held on Wednesday, October 2, at which time the new President would be installed. Dr VonderHaar reminded the Delegates that Reference Committees would convene at 1:30 PM on Monday. He then asked the House members to stand for a moment of silence in memory of KMA members who had died since the 1990 Annual Meeting.

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*\*Editorial Note: A tape recording was made of the two Meetings of the House of Delegates, and any member who wishes to examine the transcript of these Proceedings may visit the Headquarters Office and listen to the recordings.*

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Speaker Clark announced that the Rules Committee had prepared a booklet outlining the rules the House should follow in its deliberations.

Betty Schrodtt, immediate past president of the Auxiliary to KMA, presented AMA-ERF checks comprised of funds the Auxiliary had raised to benefit Kentucky's medical schools. Emery A. Wilson, MD, Dean, accepted a check in the amount of \$19,608.86 on behalf of the University of Kentucky College of Medicine; and Donald R. Kmetz, MD, Dean, accepted a check for \$34,058.15 on behalf of the University of Louisville School of Medicine.

KMA President Preston P. Nunnelley, MD, Lexington, presented the Educational Achievement Award to Ardis D. Hoven, MD, Lexington.

Speaker Clark noted that the Board of Trustees had introduced three special Resolutions. The Resolutions were read, and a motion was made, seconded, and carried to adopt each as written:

## **Resolution**

### **Memorial to W. E. "Red" Davis Board of Trustees**

WHEREAS, it was with deep sorrow that many physicians noted the passing of W. E. "Red" Davis in December 1990; and

WHEREAS, W. E. "Red" Davis has long been acknowledged in the medical community for his outstanding service to individual physicians; and

WHEREAS, his support and unselfish devotion have



touched and affected many members for the betterment of the profession; and

WHEREAS, his affable nature, spirit of goodness, and support of medicine will be sorely missed; now therefore be it

RESOLVED, that the Board of Trustees of the Kentucky Medical Association does hereby recognize with honor the commitment and service of W. E. "Red" Davis to the physicians of this Commonwealth; and be it further

RESOLVED, that this recognition be communicated to the family of W. E. "Red" Davis along with the esteem in which he is held by this Association; and be it further

RESOLVED, that this commemoration be made a permanent record in the archives of this organization.

## Resolution

### Tribute to J. Campbell Cantrill, MD Board of Trustees

WHEREAS, J. Campbell Cantrill, MD, Georgetown, has served the Kentucky Medical Association as Vice President and two full terms as Trustee; and

WHEREAS, J. Campbell Cantrill, MD, has been a member of the KMA House of Delegates and represented Scott County in an exemplary manner for many years; and

WHEREAS, J. Campbell Cantrill, MD, has served as a member of the KMA Judicial Council for 18 years, one of the profession's most arduous and time-consuming tasks; and

WHEREAS, J. Campbell Cantrill, MD, through his unselfish devotion to his chosen profession and his peers has brought great credit to medicine; now therefore be it

RESOLVED, that the 1991 KMA House of Delegates pay this special tribute to J. Campbell Cantrill, MD, for his 30 years of service to the profession and its organized bodies; and be it further

RESOLVED, that this Resolution be made a permanent part of the record of the House of Delegates and that a copy be personally presented to J. Campbell Cantrill, MD, as an expression of appreciation and gratitude.

## Resolution

### Testimonial to Carl L. Wedekind, Jr Board of Trustees

WHEREAS, Carl L. Wedekind, Jr, served with distinction as legal counsel to the Kentucky Medical Association for nineteen years; and

WHEREAS, Carl L. Wedekind played an integral role in the formation of the KMA Insurance Agency and ultimately the Kentucky Medical Insurance Company; and

WHEREAS, during Carl L. Wedekind's eleven years as President and CEO, KMIC became the largest professional

liability insurer of physicians in the Commonwealth of Kentucky; and

WHEREAS, under the leadership of Carl L. Wedekind, KMIC expanded its services and presently insures physicians and hospitals in three states; and

WHEREAS, Carl L. Wedekind has announced his retirement effective December 31, 1991; now therefore be it

RESOLVED, that the House of Delegates of the Kentucky Medical Association congratulates and wishes Carl L. Wedekind well as he enters retirement; and be it further

RESOLVED, that the House of Delegates recognizes and records its deep appreciation for the achievements of Carl L. Wedekind; and be it further

RESOLVED, that this Resolution be made a permanent part of the record of the House of Delegates and that a copy be presented to Carl L. Wedekind, Jr, as an expression of appreciation and gratitude by Kentucky physicians.

Speaker Clark introduced the officers who presented their Reports. In his Presidential Address, Dr Nunnelley noted that during his term he had tried to encourage "Pride in Medicine" by emphasizing the positive things happening within the profession. He noted especially the many tangible results of the efforts of organized medicine, including the Kentucky Physicians Care Program, which had just received the American Society of Association Executives' "Advance America Award." President Nunnelley also noted a significant increase in physician participation on KMA committees, and an outpouring of support on every issue on which members had been asked to contact their Congressmen.

Each of the Reports was assigned to a Reference Committee as noted:

Report Number		Reference Committee
1	Report of the President Preston P. Nunnelley, MD, Lexington	1
2	Report of the President, Auxiliary to KMA Betty Schrod, Louisville	1
3	Report of the President-Elect S. Randolph Scheen, MD, Louisville	1
4	Report of the Speakers, House of Delegates Danny M. Clark, MD, Somerset C. Kenneth Peters, MD, Louisville	1
5	Report of the Chairman, Board of Trustees Cecil D. Martin, MD, Carrollton	1
6	Report of the Secretary-Treasurer William P. VonderHaar, MD, Louisville	1
7	Report of the Editor A. Evan Overstreet, MD, Louisville	1
8	Report of the Delegates to AMA Donald C. Barton, MD, Corbin	1
9	Report of the Executive Vice President Robert G. Cox, Louisville	1
10	Kentucky Physicians Care Operating Committee Russell L. Travis, MD, Lexington	1

Report Number		Reference Committee	Report Number		Reference Committee	
11	KMA Physicians Services, Inc. Cecil D. Martin, MD, Carrollton	1	37	Membership Committee Harold D. Haller, Sr, MD, Louisville	6	
12	Kentucky Medical Insurance Company Richard F. Hench, MD, Lexington	1	38	Young Physicians Steering Committee J. Gregory Cooper, MD, Cynthiana	6	
13	Scientific Program Committee Sonia R. Teller, MD, Louisville	2	39	Medical Student Section Kela Joy Lyons, Louisville	6	
14	Scientific Exhibits Committee Richard A. Kielar, MD, Lexington	2	40	Resident Physicians Section Vaughn W. Payne, MD, Louisville	6	
15	Continuing Medical Education Committee Larry P. Griffin, MD, Louisville	2	41	Ephraim McDowell Cambus-Kenneth Foundation Preston P. Nunnelley, MD, Lexington	6	
16	Council for Continuing Medical Education W. David Hager, MD, Lexington	2	<b>Ad Hoc Committee Reports</b>			
17	Cancer Committee Clinton C. Cook, III, MD, Louisville	2		KMA-KMIC Ad Hoc Committee on Headquarters Building	1	
18	Physician Manpower Committee Robert R. Goodin, MD, Louisville	2		William B. Monnig, MD, Edgewood		
19	Hospital Medical Staff Section Donald J. Swikert, MD, Florence	2		Ad Hoc Long-Range Planning Committee on KMIC	1	
20	Maternal Mortality Study Committee John W. Greene, Jr, MD, Lexington	3		John W. McClellan, MD, Henderson		
21	Committee on National Legislative Activities Donald C. Barton, MD, Corbin	3	<b>New Business</b>			
22	Committee on State Legislative Activities Wally O. Montgomery, MD, Paducah	3	New Business of the House was assigned to the Reference Committee indicated:			
23	Committee on Professional Liability Insurance Wally O. Montgomery, MD, Paducah	3	<b>Resolution</b>	<b>Submitted by</b>	<b>Subject</b>	
24	Committee on Impaired Physicians Burns M. Brady, MD, Louisville	3			<b>Reference Committee</b>	
25	Committee on Care for the Elderly John C. Wright, II, MD, Louisville	3	Sub A	McCracken County Medical Society	HIV Testing for Physicians: It's Now Time	5
26	Committee on Medical Insurance and Prepayment Plans Donald R. Neel, MD, Owensboro	4	B	McCracken County Medical Society	Substance Abuse Testing: A Must for Kentucky Medicine	2
27	Committee on Claims and Utilization Review K. Thomas Reichard, MD, Louisville	4	C	McCracken County Medical Society	Economic Credentialing: Stop It Now	2
28	PRO Advisory Committee James M. Bowles, MD, Madisonville		D	McCracken County Medical Society	Kentucky Model Medical Staff Bylaws	2
29	Committee to Investigate Changing Trends in Medicine Robert R. Goodin, MD, Louisville	4	E	Pulaski County Medical Society	Access to Tobacco by Children	2
30	Committee on Maternal and Child Health Danny M. Clark, MD, Somerset	5	F	Board of Trustees	Medicare Implementation of RBRVS	5
31	Technical Advisory Committee on Physician Services (Title XIX) Harold L. Bushey, MD, Barbourville	5	G	Warren County Medical Society	Definition of Surgery	3
32	Committee on Community and Rural Health Ardis D. Hoven, MD, Lexington	5	H	KMA Young Physicians Steering Committee	1990 Medicare Fee Discrimination Against New Physicians	3
33	Committee on School Health, Physical Education, and Medical Aspects of Sports R. Quin Bailey, MD, Danville	5	I	Warren County Medical Society	Physicians Serving in Desert Storm Operation	1
34	Judicial Council Will W. Ward, MD, Louisville	6	J	Harlan County Medical Society	Kentucky as a One-Fee Area	5
35	Rural Kentucky Medical Scholarship Fund Donald R. Stephens, MD, Cynthiana	6	K	Fayette County Medical Society	Eliminating Access to Tobacco by Children	2
36	Physician-Attorney Liaison Committee Lynn L. Ogden, MD, Louisville	6	L	Jefferson County Medical Society	Fair Treatment of Physicians by the Federal Government	3
			M	Jefferson County Medical Society	Do Not Resuscitate Orders in the Pre-Hospital Setting	3
			N	Jefferson County Medical Society	Health Care Leadership	4
			O	Jefferson County Medical Society	Large Quantity Prescriptions	4
			P	Jefferson County Medical Society	Medicare Supplement Regulations	4



Resolution	Submitted by	Subject	Reference Committee
Q	Jefferson County Medical Society	Health Education and Physical Fitness Testing in Kentucky Schools	5
R	Jefferson County Medical Society	Endorsement of AMA and CDC Recommendations Regarding Health Care Workers and Blood-Borne Pathogens	5
S	Jefferson County Medical Society	Medicaid Formulary	5
T	KMA Resident Physicians Section	Prenatal Visit to Pediatrician or Family Physician	5
U	KMA Resident Physicians Section	Hepatitis B Immunizations for Medical Students	6
V	KMA Resident Physicians Section	Publication of Rape Victims' Names	3
W	Jefferson County Medical Society	Ethical Guidelines for Medical Consultants	2
X	Jefferson County Medical Society	"Gag Rule" on Pregnancy Options Counseling	3
Y	Floyd County Medical Society	Voluntary Drug Testing in Schools	3
Z	Floyd County Medical Society	Professional Review Organizations	4
AA	Calloway County Medical Society	Pharmaceutical Samples	4
BB	Calloway County Medical Society	Personal Listening Devices	4
CC	Board of Trustees	Kentucky Model Medical Staff Bylaws	5
DD	Board of Trustees	Economic Credentialing	5
EE	Board of Trustees	Commendation of the AMA	5
FF	Board of Trustees	Radon Exposure	5

Vice Speaker Peters announced the meeting locations for the Nominating Committee and for Trustee districts electing Trustees and Alternate Trustees. He reminded the Delegates that the Nominating Committee would report at the close of the first Scientific Session on Tuesday morning.

The names of the Nominating Committee members were announced: Henry R. "Hank" Bell, MD, Elkton, Chairman; John D. Ammon, MD, Florence; Ralph D. Caldrony, MD, Lexington; and Marion A. Douglass, MD, Magnolia. Dr Clark designated Dr Caldrony to serve as Acting Chairman, as Dr Bell had been unable to attend the meeting.

Dr Peters adjourned the first meeting at 10:10 AM.

## Second Meeting October 2, 1991

Speaker Clark called the second meeting of the 1991 Session of the KMA House of Delegates to order at 7:00 PM on Wednesday, October 2, 1991. Mary Wiss, MD, Pikeville, gave the Invocation, and Peter C. Campbell, Jr, MD, Chairman of the Credentials Committee, reported that a quorum was present. Dr Clark noted that Max A. Crocker, MD, Lexington; Gangadhar L. Maddiwar, MD, Martin; Samuel D. Weakley,

MD, Louisville; and Daniel Wildes, Louisville, (MSS), would serve as Tellers during the Meeting.

Secretary-Treasurer VonderHaar recognized guests from neighboring state medical associations who had attended the Annual Meeting. Included were Michael O. Mellinger, MD, President, Indiana State Medical Association; Joseph Sudimack, Jr, MD, President, Ohio State Medical Association; Constantino Y. Amores, MD, President, West Virginia State Medical Association; Arvind K. Goyal, MD, President-Elect, Illinois State Medical Society; and William H. Barney, MD, Immediate Past President, Medical Society of Virginia.

Cecil D. Martin, MD, Chairman of the Board of Trustees, made a motion, on behalf of the Board, that Charles R. Sachatello, MD, Lexington, be elected to a four-year term on the Judicial Council. The motion was seconded from the floor and carried.

The Speaker then called for the Chairmen of the Reference Committees to present their Reports.

**Editorial Note:** Unless otherwise noted, the Reference Committee action on each Report and Resolution was accepted as printed. Any opposing action taken is stated in discussion following the item.

## REPORT OF REFERENCE COMMITTEE NO. 1

**Ralph D. Caldrony, MD, Lexington, Chairman**

1. Report of the President
  2. Report of the President, Auxiliary
  3. Report of the President-Elect
  4. Report of the Speakers, House of Delegates
  5. Report of the Chairman, Board of Trustees
  6. Report of the Secretary-Treasurer
  7. Report of the Editor
  8. Report of the Delegates to AMA
  9. Report of the Executive Vice President
  10. Report of the Kentucky Physicians Care Operating Committee
  11. Report of KMA Physicians Services, Inc
  12. Report of the Kentucky Medical Insurance Company
- Resolution I — Physicians Serving in Desert Storm Operation  
(Warren County Medical Society)

## ITEMS FOR CONSENT

Reference Committee No. 1 reviewed the following items and recommends they be filed or adopted, as indicated, by consent of the House, without discussion:

2. Report of the President, Auxiliary — filed
3. Report of the President-Elect — filed
4. Report of the Speakers, House of Delegates — filed
5. Report of the Chairman, Board of Trustees — filed

6. Report of the Secretary-Treasurer — filed
7. Report of the Editor — filed
8. Report of the Delegates to AMA — filed
9. Report of the Executive Vice President — filed
11. Report of KMA Physicians Services, Inc. — filed

Mr Speaker, Reference Committee No. 1 recommends adoption of the Consent Calendar as a whole.

A motion was made from the floor that the Report of the Chairman, Board of Trustees (No. 5) be removed from the Consent Calendar, as one of its addenda, the Report of the KMA Ad Hoc Long-Range Planning Committee on KMIC, had a Recommendation, and thus needed separate action. The motion was seconded and carried.

The Report of the KMA Ad Hoc Long-Range Planning Committee was then discussed and the Speaker read the recommendations of the Ad Hoc Committee, and following the discussion, a motion was made, seconded, and carried to adopt the Report of the KMA Ad Hoc Long-Range Planning Committee on KMIC, and its Recommendation, and to file the remainder of the Report of the Chairman of the Board. (Report No. 5 and its Addenda are printed below.)

The Consent Calendar was then adopted as amended.

## Report of the Chairman, Board of Trustees

It has been my distinct privilege to serve two full terms (six years) as a Trustee on the KMA Board of Trustees and to be asked by my peers to serve as Board Chairman this past year. What an enlightening experience it has been. I urge all of our membership to get involved with your county society, the KMA, the AMA, or your specialty group where you can make a contribution to our profession, and where you can see firsthand what positive actions organized medicine takes every day to affect our professional and personal lives.

There is no such thing as a free lunch, they say, and I learned there is no such thing as a calm KMA Associational year. I thought it might be quieter than usual this year, as it was not a year for the Kentucky General Assembly regular session, but I was wrong. As you now know, a Special Session of the KGA was called and that workload was added to critical time spent on other special matters, such as Medicaid and the new program that went into effect July 1 of this year.

In addition, words cannot explain the special effort that has been put forth and is being expended as this report is being written on Medicare and RBRVS. It is *the* major change in Medicare since its inception, and the outcome of this matter will have significant and long-lasting impact on the profession and our patients. It was the primary discussion item on our trip to Washington to visit our Congressional Delegation in June, and has been the prime subject of continuing communication with our Senators and Congressmen. We have informed our membership via the "Communica-

tor," *Journal*, and special mailings, and urged our members to *all* contact their Senators and Representatives.

Added to these concerns was the necessity to move the Headquarters of KMA for the first time in 30 years. The effort, the emotions, the time, and the meetings required to finalize the sale of our headquarters building and to find and negotiate a lease on appropriate space for our relocation was an enormous task. With exceptional planning, it was all accomplished, and the move in mid-July (while staff was trying to prepare for the August Board meeting and the Annual Convention) went more smoothly than one would expect. A special appreciation goes to all of our staff for their professional preparations and implementation of a move of this magnitude.

Of course, other activities continued as usual with highlights on AIDS, PROs, Professional Liability Insurance (getting ready for the 1992 Kentucky General Assembly), health care access and care for the indigent, representation of the profession in every arena (especially with third party carriers), and concerns of all segments of the population with health care costs. As you read the many committee reports (and I hope you read each one), you will get an idea of the representation and many activities and programs conducted by KMA in your behalf.

It was, indeed, one of our busiest years ever. I was supported by the dedication and commitment of KMA members serving in every capacity, and especially by the Board of Trustees. I was proud of our actions and our accomplishments. I am pleased to have had the privilege of serving as Chairman of the Board and thank each of you for that honor and opportunity.

The following summary of Board meetings is submitted to give you a snapshot of the scope of your Board's activities. Complete Minutes of all Board meetings will be provided to Reference Committee No. 1.

## SUMMARY OF BOARD MEETINGS

### First Meeting, September 27, 1990

Acting as temporary Chairman, KMA President-Elect, S. Randolph Scheen, MD, introduced the newly elected members of the Board and the new officers: William B. Monnig, MD, Edgewood, Vice President; William P. VonderHaar, MD, Louisville, Secretary-Treasurer; Joseph E. Kutz, MD, Louisville, Trustee, 5th District; Mark F. Pelstring, MD, Trustee, 8th District; and Paul R. Smith, MD, Trustee, 15th District; Robert R. Goodin, MD, Louisville, Delegate to AMA (effective January 1, 1991); and Bob M. DeWeese, MD, Alternate Delegate to AMA (effective January 1, 1991).

The Board elected the Executive Committee members to serve with the President, President-Elect, Vice President, and Secretary-Treasurer for the 1990-91 KMA year. Cecil D. Martin, MD, Carrollton, was elected Chairman of the Board,



and Lucian Y. Moreman, II, MD, Elizabethtown, was elected Vice Chairman. John W. McClellan, MD, Henderson, and William H. Mitchell, MD, Richmond, were named as Trustees-at-Large.

It was noted that the KMA Executive Committee members also serve as the Board of Directors of KMA Physicians Services, Inc (KMA's holding company). The Board also made changes to the Kentucky Foundation for Medical Care Board of Directors in accordance with KFMC's Bylaws, and appointed KMA committees for the following year.

The Board voted to hold the 1991 Annual Meeting on September 27-October 3 at the Hyatt Regency Hotel and Lexington Center.

## **Second Meeting, December 12-13, 1990**

Convening in a regular session, the KMA Board of Trustees held a two-day meeting on December 12 and 13. Oral reports were given, including those of the President, the Secretary-Treasurer, the Senior Delegate to AMA, the Dean of the University of Kentucky College of Medicine, and representatives of the Board of Medical Licensure, the Kentucky Medical Insurance Company, and Sentinel Medical Review Organization.

A special presentation was made to Joe A. and Cecil Dulin Wallace, owners of the Cambus-Kenneth Farm in Danville, in appreciation for their bequeathal of the farm to the Ephraim McDowell Foundation. A plaque was also presented to David W. Kinnaird, MD, Louisville, for his dedication to the McDowell House and for his assistance in forming the Foundation.

It was noted that KMA membership had reached an all-time high of 3,722 Active members, and 5,600 members in all categories. William T. Applegate, Executive Director, was congratulated for his installation as President of the Professional Convention Management Association, a position also previously held by KMA EVP Robert G. Cox.

The Board took action on various matters, including submitting the name of Robert R. Goodin, MD, Louisville, for appointment to the AMA Advisory Committee on Continuing Medical Education of the Council on Medical Education; endorsing guidelines proposed by the Committee on School Health for institutions wishing to conduct sports medicine seminars for high school athletic coaches; and authorizing the implementation of a no-smoking policy in the KMA Headquarters Office.

The Board members also held a lengthy dialogue with representatives of Kentucky Blue Cross and Blue Shield regarding the KMA-endorsed BCBS plan for the membership, and approved terms of the plan renewal, as recommended by the KMA Committee on Medical Insurance and Prepayment Plans. Appointments were made to the KEMPAC Board of Directors; the *Journal* Editorial Board; and the KMIC Board Election Nominating Committee.

Detailed reports were given concerning the activities of the Committees on National and State Legislative Activities, the Technical Advisory Committee on Physician Services (Title XIX), and the Kentucky Physicians Care Program. It was reported that Kentucky had been chosen for a pilot study on developing new CPT codes for Medicare billings, and that Board members would be asked to participate by keeping logs for a two-week period.

Legal Counsel reviewed an article regarding "Release of Patient Medical Records," intended to answer questions about the ownership, release, and retention of patients' records, in light of recent court decisions.

The next meeting of the Board was scheduled for April 10-11, 1991.

## **Third Meeting, April 10-11, 1991**

The KMA Board of Trustees met on April 10-11, 1991, at the KMA Headquarters Office in Louisville.

The Board members heard reports from the President; the President of the Auxiliary to KMA; the Secretary-Treasurer; the Senior Delegate to AMA; the Secretary of the Board of Medical Licensure; and the Chairman of the Board of KMIC. Other guests who made presentations to the Board included David B. Stevens, MD, Chairman of the KEMPAC Board of Directors; James B. Holloway, Jr, MD, Medical Director, Medicare Part B; Dwight L. Blackburn, MD, Executive Director for Physician Relations, Kentucky Blue Cross and Blue Shield; and David Tao, MD, Medical Director for Sentinel Medical Review Organization.

KMA President Preston P. Nunnelley, MD, reported on a Health Care Summit held in March, and made a presentation to Ballard W. Cassady, MD, who was retiring as Board Chairman of the Kentucky Medical Insurance Company.

Reports were given by the Chairman of the Committee on National Legislative Activities and the Technical Advisory Committee on Physician Services. A detailed report was given on the recently completed Special Session of the Kentucky General Assembly, which dealt with such topics as DUI, solid waste disposal, and the adoption of a Medicaid Assessment Program. Items expected to be introduced into the 1992 Kentucky General Assembly were also discussed.

Direction was given to submit the findings of the KMA Committee on Maternal/Fetal Conflict to the Governor's Task Force on Alcohol and Drug Use During Pregnancy, and to accept the invitation of the Kentucky Center for Public Issues to endorse "Election 91: Candidate Closeup," which will air individual interviews with Kentucky's gubernatorial candidates on KET.

The Board members adopted a budget for the 1991-92 Associational year, approved a slate of directors to be elected to the KMIC Board, and authorized the KMA Executive Committee and KMA/KMIC Building Committee to determine the best course of action to alleviate space problems in the head-



quarters building.

The Board also selected names for submission to the Governor for the Kentucky Board of Medical Licensure and the Board of Nursing Advisory Council, and appointed William P. Hoagland, MD, Louisville, to the Editorial Board of the *KMA Journal*.

The Chairman announced that the Board would hold its next meeting in August.

#### **Fourth Meeting, May 14, 1991 (Special Meeting)**

The Board of Trustees met in special session on May 14, 1991, to consider a recommendation of the KMA Executive Committee that KMA sell its headquarters building on Ephraim McDowell Drive to Hospice of Louisville, Inc. The Board was advised that the Ad Hoc Committee on Headquarters Space had thoroughly investigated all possible alternatives to procure more space for the operation of KMA and KMIC. Since the Boards of both organizations had expressed a preference for the companies to remain in the same physical location, the Ad Hoc Committee and Executive Committee had determined that the best course at this time would be to sell the building and lease space for a five-year period.

The Board reviewed figures which outlined the net profit to be realized from the sale of the building, estimated interest income which would be earned on the profit, and savings on fixed expenses, such as property taxes, insurance on the building, and maintenance costs. After carefully reviewing the material presented, the Board of Trustees accepted the recommendation of the Executive Committee to sell its headquarters building to Hospice of Louisville, Inc, lease space for five years, and consider building or buying another headquarters building in the future.

#### **Fifth Meeting, August 7-8, 1991**

The KMA Board of Trustees held its fifth meeting of the Associational year on August 7-8, 1991, at the Oxmoor Steeplechase Clubhouse. Reports were given by the President; Secretary-Treasurer; Commissioner for Health Services; Dean, U of L School of Medicine; Medical Director of the Medicare Part B Program; and a member of the Board of Medical Licensure. The new President and CEO of the Kentucky Medical Insurance Company, Steven L. Salman, was introduced, and he presented a brief report.

President Preston P. Nunnelley, MD, reported that the sale of the KMA Headquarters Building to Hospice of Louisville, Inc, should be completed in early September, and he noted that space had been leased for the KMA staff in the Forum Office Park on North Hurstbourne Parkway for a five-year period. Doctor Nunnelley presented a bound set of *Journals* to Nelson B. Rue, MD, Immediate Past President, which were published during his term as President.

The Senior Delegate to AMA highlighted actions taken at the AMA Annual Meeting in June, which included lengthy discussions on HIV testing and Medicare Physician Payment

Reform. It was noted that KMA had encouraged its membership to write to the Kentucky Congressional Delegation regarding concerns relating to the RBRVS issue.

It was reported that the PLI campaign is in full swing, and that the Gallup Poll of 1,000 consumers and 150 legislators and business people, which is being conducted for KHA and KMA, is expected to be ready by October. The intent of the poll is to determine attitudes regarding health care costs, access to care, and concerns with the malpractice situation.

The Board reappointed all current *Journal* Editors for additional two-year terms; joined with several other groups in endorsing the posthumous nomination of Nicholas J. Pisacano, MD, for the AMA Benjamin Rush Award; and submitted the name of W. Stephen Aaron, MD, Louisville, for nomination to the HCFA Practicing Physicians Advisory Council. It was also agreed to invite Alternate Trustees to attend the Sunday, September 29, meeting of the Board of Trustees to be held during the Annual Meeting.

The Board authorized a \$10 voluntary assessment for the Legal Trust Fund to be included with the 1992 dues billing.

The ad hoc committee reports of the Board were finalized, and a review was made of each final report submitted by the KMA committees. A listing of actions taken to implement the directives of the 1990 House of Delegates was distributed, and it was noted that the same information would be sent to every Delegate as an addendum to the Board Chairman's Report to the 1991 House of Delegates. The Board also approved several Resolutions for introduction into the House.

The next meeting of the Board was scheduled for Sunday, September 29, 1991.

#### **Executive Committee**

Eight Officers and Trustees comprise the KMA Executive Committee and four of these eight (President, President-Elect, Chairman of the Board and Secretary-Treasurer) serve as the Quick Action Committee. The Executive Committee meets between sessions of the full Board to guide the day-to-day operations of the Association and to make recommendations on major matters coming before the Board requiring more extensive consideration. The Quick Action Committee meets when spur-of-the-moment decisions are essential, and also meets on a weekly basis during legislative sessions.

The Executive Committee will log at least seven meetings this year, and the Quick Action Committee will have met six times by the time you read this report. The members serving you in these capacities have more than proven their desire to serve their profession, as the amount of time required and given is a sure sign of total dedication and commitment.

The Quick Action Committee worked its way through the Special Session without the guiding hand of Past Presi-



dent and State Legislative Chairman Wally Montgomery, MD. Wally was one of our many members who served as a part of Operation Desert Storm in Saudi Arabia. We were extremely proud of Wally and each and every one who served. We again welcome them all home.

## **Ad Hoc Committees**

The three ad hoc committees of the Board working this year were those on (1) KMA/KMIC Committee on Headquarters Building, (2) Long-Range Planning Committee on KMIC, and (3) Nomination of KMIC Board Members.

The KMIC Board Election Nominating Committee, chaired by Kelly G. Moss, MD, submitted its nominees for KMIC Board positions at the April Board meeting. Donald C. Barton, MD, Corbin, was elected as a new member of the KMIC Board, and Richard F. Hench, MD, Lexington, and James R. Wilkinson, MD, Paducah, were re-elected to the KMIC Board. Special recognition was given to Ballard Casady, MD, Pikeville, who retired from the Board. Doctor Casady had served as Chairman of the KMIC Board since its inception and received much praise and deserving recognition from the KMA Board of Trustees. Doctor Hench, a KMA Past President, was elected as the new KMIC Board Chairman.

In closing, I again thank the Board and committee members and the KMA staff for their hard work and strong support. We must continue to strive for a unified profession as we look to the future and maintain our advocacy for our peers and our patients.

**Cecil D. Martin, MD**  
**Chairman**

## **Report of the KMA-KMIC Ad Hoc Committee on Headquarters Space**

### **Addendum to the Report of the Chairman, Board of Trustees**

The KMA Headquarters Building has housed the KMA and Kentucky Medical Insurance Company staffs since KMIC's inception in 1979. The growth of KMIC has put increasing pressure on space availability in the Headquarters Office, and last year, it was agreed a solution must be found.

The Executive Committee authorized the appointment of the KMA/KMIC Ad Hoc Committee on Headquarters Office Space and charged it with attempting to determine future space needs of KMA and KMIC, and to make a recommendation to the KMA Board of Trustees.

The Boards of both KMA and KMIC had voiced their desires to have the two staffs continue to operate from a common location, rather than split and go separate ways. With this premise, the Building Committee researched a number of alternatives, to include adding another addition to the

present building. Other alternatives discussed would require leasing or selling our own building, and building a new one, buying an existing one, or leasing space for a period of time before making a long-term commitment.

Detailed studies were made regarding every possible approach to increasing our office space. We were unable to secure additional land to meet our parking space requirements, and an appropriate building to purchase in an acceptable location was not available. As developments progressed, it became clear that constructing a new building was not feasible because of time constraints.

While real estate is experiencing a "down market," we had studies made of our property, but had not put it on the market. Word got around that we were looking for additional space, however, and a real estate agent with whom we were working had a client interested in purchasing our Headquarters Building. That client was Hospice of Louisville, Inc, a non-profit health organization. A negotiated price proved to be agreeable to us. We were pleased to find another health service organization with an interest in our building.

Much of our work was done as a team; ie, this Ad Hoc Committee, the KMA Quick Action Committee, and the KMA and KMIC Executive Committees. In selling the KMA Headquarters Building, it is our intention to lease for five years and then take a serious look at buying or building a new Headquarters Office. It was with that understanding that we agreed to sell when we could get a fair price, because we did not feel the open market would bring an appropriate price should we delay the offer we had. Five years from now we will better know if we should buy or build in conjunction with KMIC, as is now our intention; or if for reasons that might exist then, we should pursue separate headquarters locations.

Making that decision, the combined committees then met to select a building in which to lease space, and after much work and careful consideration, we signed a contract to lease in the Hurstbourne Forum Office Park (Building I). Our new address is:

Suite 200  
301 N Hurstbourne Parkway  
Louisville, KY 40222-8512  
(502) 426-6200  
(502) 426-6877 (FAX)

With the proceeds from our building sale, we are maintaining a KMA Building Fund. While we will be deducting lease payments from it, it is still our expectation that the Fund will be larger five years from now than if we had had the flexibility of waiting five years to sell the current building. The entire Board of Trustees, except one member, voted for the action that has been taken, and we feel it was definitely in the best interest of the Association.

**William B. Monnig, MD**  
**Chairman**

## **KMA Ad Hoc Long-Range Planning Committee on KMIC**

### **Addendum to the Report of the Chairman, Board of Trustees**

The KMA Ad Hoc Long-Range Planning Committee on KMIC is made up of the 15 Trustees and was established as an additional communication link between KMIC and the Kentucky Medical Association.

We have met just prior to regular quarterly meetings of the Board of Trustees and have received reports from the staff of KMIC, and have discussed the present status of KMIC and the other 41 physician-sponsored professional liability carriers throughout the country.

We became familiar with the Physicians Insurers Association of America (PIAA) which is the organization of all physician-sponsored insurance companies, and were advised of how KMIC Board members have been active in that organization. We reviewed data on the growth and development of all the PIAA companies and discussed the potentials for their future development.

Carl L. Wedekind, Jr, President of KMIC, presented to us some concepts for the future development of KMIC and the potential strengths of joint ventures among the various PIAA companies.

It is the opinion of the Committee that it is in the best interests of the membership of the Kentucky Medical Association that KMIC remain a financially strong, aggressive provider of professional liability insurance, and that the Board of Trustees be encouraged to explore ways that KMIC can deal effectively with changing times and be a leader in the long-term development and growth of physician-sponsored insurance companies.

It has been recommended to the Committee by the President of KMIC that the establishment of a corporate holding company in conjunction with KMIC would provide more flexibility to both KMIC and KMA to deal with future developments in the professional liability field. It is the opinion of the Committee to accept these recommendations in the following form.

We recommend that the KMA House of Delegates grant to the Board of Trustees authority to restructure the ownership of KMIC so that a holding company can be established and KMIC will have the flexibility to become a part of a larger group of companies, should that be desirable.

Under this arrangement, KMA could exchange its Class B stock for holding company stock but retain the right to maintain control over the election of KMIC Board members upon terms which are acceptable to KMA. In the event KMA ever wanted to, it would have the option to reacquire its Class B stock.

All such proposed future developments will be finalized only upon the satisfaction of the KMA Board of Trustees with all terms and conditions.

The following background will present information and answer questions on this proposal:

### **Questions & Answers**

**1. Q. What are "the changing times" in physician-sponsored professional liability companies the Committee refers to?**

**A.** There are 42 physician-sponsored companies throughout the United States that were founded by medical societies just as Kentucky Medical was and at about the same time. All of these companies have grown, as has Kentucky Medical, and consideration is now being given to closer cooperation between physician-sponsored companies, particularly on a regional basis. All of these companies need to grow in order to remain healthy and provide quality services to physicians.

**2. Q. How has Kentucky Medical been a leader in the field of physician-sponsored companies?**

**A.** Kentucky Medical was one of the first to promote the voluntary change over to the claims-made format and now all the companies have done that either voluntarily or involuntarily.

Kentucky Medical was started as a stock company, and now many of the other mutual companies are either switching or planning to switch to being stock companies.

Kentucky Medical has been a leader in developing and presenting risk management courses for physicians and their staffs.

**3. Q. Why is it recommended that we set up a holding company? What is wrong with the present corporate setup?**

**A.** There is nothing wrong with the current setup for the present time. It has worked well for both KMA and Kentucky Medical.

A holding company is being recommended now to prepare for future developments. The holding company concept will permit Kentucky Medical to remain basically the way it is now, but be part of a larger multi-state entity in the future, if that is desirable.

**4. Q. How is it proposed the holding company be set up?**

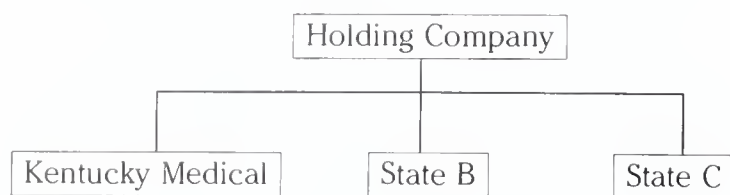
**A.** A corporation will be founded by filing Articles of Incorporation in Frankfort and the stock of this company will be totally owned by KMA. This corporation will be a nonoperating shell, but will be available as a holding company if the right opportunity arises.

**5. Q. What might be a "right opportunity"?**

**A.** An opportunity might arise for Kentucky Medical to join with one or more other physician-sponsored companies in a merger where Kentucky Medical would con-



tinue to operate in Kentucky just as it does now, but be a part of a larger, developing and growing entity. The chart would look like this:



**6. Q. How could Kentucky Medical continue to operate in Kentucky as it does now, if it were a part of a holding company?**

**A.** As part of the agreement, the KMA would have a contract with the holding company whereby KMA would nominate three-fourths of the directors (as it currently elects) and those Directors would be elected by the holding company. The difference would be that KMA-selected directors would agree that Kentucky Medical would be operated in a fiscally prudent manner, as it is currently operated. If, for instance, Kentucky Medical decided to charge discounted rates until it went broke, the holding company could step in and require that policy be changed. If, as another example, Kentucky Medical decided to place its investments in junk bonds and Texas real estate, the holding company would require that prudent investment policies be followed. These sound fiscal guidelines would be spelled out in the Agreement.

**7. Q. If Kentucky Medical were to continue to operate as it does now with KMA still controlling it, what would be the advantage of having a holding company?**

**A.** The holding company would have a consolidated balance sheet of all three companies in the system and would be able to better negotiate reinsurance treaties for all three companies because of the combined financial clout, be able to save on some consolidated operating costs, and be able to promote better products at lower costs.

**8. Q. Why can't we merge with or acquire other companies without a holding company, using Kentucky Medical as the controlling company?**

**A.** We could in theory, but in practice other physician-sponsored companies would not agree to KMA controlling them as KMA controls Kentucky Medical. Using the holding company concept, each of the joining companies can keep their ties to their own medical society and still be a part of a stronger, unified whole.

**9. Q. For the holding company to function, would KMA trade its Class B voting stocks for holding company stock?**

**A.** Yes. KMA would exchange its Kentucky Medical Class B voting stock in return for holding company stock and a contract authorizing KMA to continue to control Kentucky Medical as it does now, so long as agreed upon, prudent financial practices are followed.

**10. Q. Suppose we did this and it didn't turn out the way we wanted, could we reverse the process and get our Class B voting stock back?**

**A.** Yes. As part of the agreement, KMA would have the continuing option to reacquire the Class B voting stock for the same consideration as the original transfer.

**11. Q. If we set up the holding company and no opportunities come along, what will be the status of KMIC and the holding company?**

**A.** KMIC will continue to operate just as it is now and the holding company will be in a KMA drawer as a nonoperating shell corporation.

**12. Q. Suppose what appears to be a good opportunity comes along, what is the procedure for accepting or rejecting?**

**A.** Kentucky Medical would be responsible for analyzing the opportunity and, if it were favorable, KMIC would make recommendations to the KMA Board of Trustees. The KMA Board would have the final say on whether or not to take the opportunity, on the terms of the agreement on continuing control of Kentucky Medical, and on the option to reverse the process later if it didn't work out. Thus, the Kentucky Medical (KMIC) Board would propose the deal, and the KMA Board of Trustees would make the final decision.

**13. Q. Are there any specific opportunities available now that Kentucky Medical is looking at?**

**A.** No, there is no active opportunity sitting in the wings.

**14. Q. Why do you want to do this now? Why not wait until you have a specific proposal in mind?**

**A.** We recommend doing it now so that the corporate structure can be in place and the procedures for consideration and approval or rejection can be agreed upon in advance.

It is clear that if and when a good opportunity should appear, it is essential that the parties have the authority to analyze the situation, negotiate terms, and take action either pro or con in a decisive and timely fashion. That is the purpose of these recommendations.

**John W. McClellan, MD**  
**Chairman**

## RECOMMENDATIONS:

1. The KMA Ad Hoc Long-Range Planning Committee on KMIC recommends that the KMA Board of Trust-

ees be given the authority to restructure the ownership of KMIC so that a holding company can be established and KMIC will have the flexibility to become a part of a larger group of companies, should that be desirable.

## Remaining Consent Calendar Items

## Report of the President, Auxiliary

Our 1990-91 year has been a time dedicated to "Improving the Image of Medicine." Every member has worked toward this goal. At a time when the prestige of physicians is falling and patient-physician relationships are weak, there must be a way to return the practice of medicine to its past ideals.

One different and new idea this year was to increase our scholarship monies. We raised some extra money by donations but not by the \$30,000.00 which the Health Careers Fund Committee hoped for. Every year we have 25 to 45 applications with just a few receiving the help they need.

The Auxiliary was asked by the Kentucky Medical Association to have a member sit on the board of KCAN (Kentucky Coalition on the Availability of Nurses). This has been a very active and rewarding experience for our Auxiliary representative. Some of the organizations involved with and working toward this problem are: Kentucky Home Health Association, Kentucky Homes for the Aging, Kentucky Chamber of Commerce, Kentucky Cabinet for Human Resources, Kentucky Hospital Association, and most all of the nursing associations. With this coalition of fine organizations, one can understand how concerned Kentucky is with the shortage of nurses.

Doctors' Day was unusual this year with the Gulf Crisis. Many of our Kentucky physicians (about 60) were called to active duty. Their spouses were left behind to care for the children, homes, offices, and finances; yet, our Auxiliary members who were so busy with these efforts found time to work toward the causes of our Auxiliary. Thanks one and all for this.

Every committee chairperson on the board contributed to the progress of our Auxiliary. Without each person's dedication to their job, this year could not have been so successful.

Our AMA-ERF Committee worked hard and diligently. Everyone involved with this state and county committee realizes the importance and necessity to make money to further medical education. Each year our state wins awards at the national convention for increasing totals of previous years. This year the awards were as follows:

AMA-ERF Achievement Award for raising the 2nd largest per capita contribution — \$54.82.

AMA-ERF Achievement Award for raising the 5th greatest

amount of contribution — \$68,040.00.

AMA-ERF Achievement Award for the Auxiliary to the Boyd County Medical Society for raising the largest per capita contribution — \$192.63.

**Betty Schrodt**  
**AKMA President**  
**1990-91**

## Report of the President-Elect

I am honored to be able to report to you as President-Elect. I would like to affirm that I have greatly enjoyed this year's service in this capacity, and I am pleased to have provided another year of service on the Board of Trustees to this Association.

Just as society has seen many cataclysmic changes in the world community this year, a number of major events have occurred at KMA about which you can find more details in other reports. Notably, we experienced a major revision to the Medicaid Program, with imposition of an assessment on physician payments and increased reimbursement. The situation has yet to be fully realized, but I am hopeful that it will be the benefit to patients and the profession that we all wish it to be.

This year many of our colleagues were called to serve in the Persian Gulf, and all those called did so with unswerving devotion and overt dedication to medicine and our nation's needs. During that difficult period, our active service colleagues were supported here at home by partners and friends who took over busy practices, and even treated the families of those on active duty at no charge.

The KMA Headquarters was relocated this year, which was a major emotional, as well as physical, move. Many of us have strong attachments to the old quarters on Ephraim McDowell Drive. Even the name of the street evokes nostalgia for events that occurred during many years with friends and adversaries. The new office location is attractive, prestigious, and comfortable, and while some will miss the old building, the new quarters certainly lend themselves well to the dignity of our organization.

I am particularly gratified with the efforts of our President, Preston Nunnelley, and his work this year. The theme Preston chose for his year's efforts, "Pride in Medicine," was never more pertinent or critical than it is today, and I commend him for his dedication and sheer hard work in all areas of KMA's activities.

Even though I have been closely involved with KMA for a number of years, my faith in its capacities got a greater affirmation this year. It is an act of faith in our profession that so many talented, dedicated people continue to rise from the ranks to serve medicine and KMA. It gives me great pride to be a part of this organization, and I am humbly honored to have been chosen to serve you. I pledge my full commit-



ment, and will rededicate my efforts this year to be of continuing service to you, and sincerely seek your support.

**S. Randolph Scheen, MD**  
**President-Elect**

## Report of the Speakers, House of Delegates

Your Speakers would like to welcome you to the 141st Annual Meeting, and are hopeful that we will see frank and open debate. A number of materials have been provided to you which constitute the business of the House, and additional information will be disseminated at the meeting. It is most important that you review this material and share it with the colleagues in your district so that you can represent the broadest perspective possible.

The Speakers stand ready to assist any individual or group of members wishing to bring additional matters before the House and are, and will remain, available to all Delegates throughout the meeting.

We direct your attention to the schedule and hope that you will note that Reference Committee meetings will begin earlier than in the past, at 1:30 PM, Monday, September 30. Steps have been taken to make the meeting facility as accommodating as possible to our needs, although some inconveniences may be experienced.

It is our firm intent to serve the House and the membership, and we earnestly solicit any comments, questions, or suggestions you may have.

**Danny M. Clark, MD**  
**Speaker**

**C. Kenneth Peters, MD**  
**Vice Speaker**

## Report of the Secretary-Treasurer

It is a pleasure to present my first report to you as Secretary-Treasurer. As I have become more involved in the activities of the Association, I am truly impressed with the breadth and depth of issues that are dealt with.

It was my privilege to join the Board of Trustees as a member this year. Other new board members include Joseph Kutz, MD, Louisville; Mark Pelstring, MD, Covington; and Paul Smith, MD, London.

Continuing along the lines of internal personnel matters, the KMA *Journal* received Honorable Mention in the "Medical Journalism Award" contest for excellence in design and editorial content. Congratulations are due to Evan Overstreet, MD, and Sue Tharp of the staff, who serves as Managing Editor. Also this year, Bill Applegate, Deputy Executive Vice President, assumed the office of President of the Professional

Convention Management Association. This is a distinct honor for Bill, as well as for KMA.

At the beginning of the Associational year, the Kentucky Supreme Court ruled the five-year statute of limitations to be unconstitutional. As a result, counsel was requested to develop guidelines for maintenance of medical records, and these guidelines appeared in the January issue of the *Journal*.

At the beginning of the year, a special session of the Legislature was called which culminated in the passage of HB 21, or the new Medicaid Assessment process. This consumed numerous hours by officers and staff, as well as a special meeting of the Board of Trustees and Executive Committee. In addition, the interim committee system has continued through the year and has addressed matters such as the definition of a physician's office, medical waste disposal, cost of health care, AIDS, and other issues. This requires a full-time effort on the part of staff, and the officers are routinely called on to testify and attend various legislative sessions.

Membership increased by approximately 133 members over last year, with a slight increase in dues-paying members, as of August 1991.

One of the most dramatic changes to the Association this year has been the relocation of the KMA Headquarters because of space limitations which had become untenable for KMA and KMIC. As part of the relocation process, the Quick Action Committee met on several occasions, the Executive Committee was convened twice, and the Board was called in special session once to hear presentations and make decisions on relocation, as well as to approve and finalize terms for the sale of the old building. The new headquarters office is located at 301 N Hurstbourne Parkway in the Forum building complex. This beautiful building is located in a park-like setting, and projects an excellent image for KMA.

The old building was purchased by Hospice of Louisville, which is a highly respected organization. Tentative plans are for KMA to lease its new space for approximately five years and then consider the purchase or building of new quarters.

This brief overview of events, hopefully, will provide some indication of many of the significant activities that occur within your Association. I respectfully urge your attention to the other reports contained in this book for details about the efforts of the committees which routinely meet to serve the profession and the Association. All of this work is the result of the efforts of many individual members and staff, and all are due our humble thanks.

I am honored to have been selected to serve as Secretary-Treasurer, and pledge my continuing best effort to the position.

**William P. VonderHaar, MD**  
**Secretary-Treasurer**

## Report of the Editor

The *Journal of the Kentucky Medical Association* continues to maintain its position as one of the finest state publications by assembling for its readers authoritative, concise, thoughtful, substantive, and interesting scientific articles and special feature stories. The *Journal* exists to assist each physician in maintaining a general awareness of progress and change in clinical medicine and to provide an open forum for the discussion of issues vital to the physicians of Kentucky. As a depository for important information and ideas, the *Journal* remains a popular and important benefit of membership in the Association.

In 1990, for the first time ever, the *Journal* earned national recognition by winning Honorable Mention in the 16th annual Sandoz Pharmaceuticals medical journalism competition. In the state journal category, a first award and four honorable mention awards are given.

The Sandoz awards, which recognize the unique importance of state and local professional journals, are based on outstanding design and editorial content. Judges for the competition are professionals of national repute in the publishing field. Judge Paul Fisher, retired journalism professor at the University of Missouri, included these comments in describing the KMA *Journal*. "It has a very certain, very assured style. The word we might use for it is elegant. Nothing blatant. It is simple and at the same time distinctive, and when you can meld these two together, being simple and being distinctive, then of course, you have a piece of work on your hands. Graphically, the *Kentucky Journal* is ranking up with the very best that are entered in this division."

During 1990-91, the *Journal* continued to attract an ever-increasing number of high-quality scientific articles from Kentucky physicians, medical schools, hospitals, clinics, and guests. Its pages featured 28 original scientific articles representing the efforts of 94 authors; 4 Grand Rounds contributions from the University of Kentucky and University of Louisville medical schools representing 13 authors; Clinical Notes on Aging articles; the entire proceedings of the 1990 KMA Annual Meeting; several insightful reviews written by Book Review Editor Stephen Z. Smith, MD; Auxiliary updates; as well as numerous editorials and articles on special topics such as socioeconomic factors, state and federal legislation affecting medical practice, office management, and our national federation (namely, the AMA).

To maintain its integrity, the *Journal* can be and should be selective in choosing scientific articles. We ask that articles be original and not submitted to other publications and that our Editorial Board be allowed the prerogative of revising, rewriting, making suggestive changes, or rejecting the material which is submitted. Any submitted material is scrutinized by each member of the Editorial Board and final decisions are made with the intent of selecting material which is new or current, well-written, accurate, nonself-serving, and

that will augment the principles of the KMA. There were 12 Board meetings during the 1990-91 year, and of the 45 scientific manuscripts reviewed, the Editors rejected 12, indicating a 27% rejection rate.

The strength of the *Journal* rests with the quality of the people who serve on the Editorial Board. Each of our editors has unique qualities in producing the *Journal*, and each has done a difficult and time-consuming service for the Association. I wish to personally thank the other Board members for giving generously of their time: Doctors Daniel W. Varga, Scientific Editor; Stephen Z. Smith, Assistant Scientific Editor; and Jannice O. Aaron, Martha Keeney Heyburn, William P. Hoagland, and Milton F. Miller, Assistant Editors.

During this past year the *Journal* lost two of its Board members. Paul C. Grider, MD, Scientific Editor for 16 years, and McHenry S. Brewer, MD, who had served for eight years, resigned due to other commitments. The Board accepted their resignations with regret. Their guidance and support are truly missed.

We continue to welcome from our members and the Auxiliary personalized accounts of their activities and interests. Through reports of notable events, ie, awards, appointments, medical missions abroad, obituaries, and other professional events of interest, our readers can stay in touch with their colleagues. Also, the *Journal* is a great tool for broadcasting the points of view of KMA members — we encourage your letters to the editor.

The costs of the *Journal* have been significantly controlled, with the exception of a postal increase. Effective January 1991, the *Journal* received approval for a modest advertising rate increase, the first overall increase since 1987. This, combined with a printing contract which continues to hold annual increases at the 3% level, changes in paper, and aggressive pursuit of local advertising contributed to the budget control. Although national pharmaceutical advertising continues the dramatic slide begun in 1986, our local advertising remains strong. We are pleased to report that of the 31 state journals represented by the State Medical Journal Advertising Bureau (SMJAB), our *Journal* was one of only 13 that showed an increase in 1990 over 1989.

To improve the *Journal's* image with the advertising community, funds were authorized for printing new, professional media kits. These are being sent to all advertising agencies in the Greater Louisville, Lexington, and Northern Kentucky areas in an effort to expose the *Journal* to advertisers who are not aware of our existence. They are also sent to companies and individuals who inquire about advertising. This should prove to be an excellent resource for promoting statewide advertising.

The Editorial Board serves at the pleasure of the Board of Trustees and appreciates its support in allowing us to bring you a *Journal* that keeps you current on the policies and decisions of the Kentucky Medical Association and Board of Trustees concerning issues facing our profession nationwide



as well as locally and to make you proud to be a member.

We take the concerns of our readers seriously. We welcome your advice and counsel. We're listening.

**A. Evan Overstreet, MD**  
Editor

## Report of the Delegates to AMA

Your delegation to the American Medical Association had a most active year. You were represented at the Interim Meeting, which was held last December in Orlando, Florida, and the Annual Meeting, held in Chicago on June 23-27.

It is probably important to note that in addition to the four Delegates and Alternates which you elected, the delegation also consists of attending officers; representative of the Medical Student Section, Resident Physicians Section, Young Physicians Section, and Hospital Medical Staff Section; and representatives from some county medical societies. At the Interim Meeting, the delegation was somewhat diminished by the absence of Wally O. Montgomery, who was on active duty with the military. Doctor Montgomery has since returned, with our heartfelt welcome.

At the meeting, the Kentucky delegation considered resolutions and reports dealing with gun control. This attention was directed by the KMA House of Delegates and called for the restriction of sale of large-capacity magazine, high-rate-of-fire weapons. The issue did not see closure, but did receive a lot of discussion.

A second referral from the KMA House of Delegates was Resolution N on AMA accountability. This directed Kentucky's Senior Delegate to seek information regarding salaries of senior AMA executives and other compensation and make it available to the KMA Board of Trustees. This issue was very adequately addressed by the AMA House, and procedures ensuring accountability are now in effect.

Surrounding this meeting, it was learned that a possible position on the AMA Advisory Committee on Continuing Medical Education was open, and the Delegation took steps to promote Bob Goodin for this position. The Interim Meeting also marked the last meeting of Ken Crawford, who has devoted 16 years of service as a Delegate and Alternate Delegate.

At the Annual Meeting, John Clowe, a family physician from New York, was elected President-Elect. Reelected to the Board of Trustees were Lonnie Bristow, California; Ray Scalettar, District of Columbia; Jerald R. Schenken, Nebraska; and Percy Wootton, Virginia. Elected as Speaker of the House was Daniel Johnson, Louisiana; and as Vice Speaker, Richard Corlin, California. Also at this meeting, Christa Singleton, one of Kentucky's medical students, was a candidate for a

position on the MSS Governing Council, which she did achieve with the support of the delegation.

A major part of discussions at this meeting surrounded implementation of the Medicare physician payment reform plan, or the RBRVS. At the meeting it was noted that Congress had intended for the plan to be budget-neutral, but regulations promulgated in June established that a conversion factor might well result in an actual reduction in payments. It was agreed to devote all resources necessary to resolve this situation, and prior to the KMA Annual Meeting, an intense lobbying effort took place throughout the entire Federation, which resulted in elimination of major cuts that the conversion factor would have accomplished.

Regarding HIV testing, the AMA House adopted the following policy measures:

- Hospitals, clinics, and physicians may adopt HIV testing based on local circumstances;
- Routine HIV testing should include appropriate modified informed consent procedures;
- All negative results should be provided in a confidential manner;
- All positive HIV results should be provided in a confidential, face-to-face session by a properly trained professional;
- When an individual requests information about HIV, full pre-test and post-test counseling should be utilized;
- State medical associations are encouraged to seek modification of state laws that restrict the possibility of routine testing;
- Physicians, health care workers, and students should be tested in appropriate situations.

It has been our pleasure to serve you this year, and we would welcome any comments or questions from the membership.

**Donald C. Barton, MD**  
Senior Delegate

## Report of the Executive Vice President

This has been a successful but tumultuous year for KMA due to several unexpected events. The Kentucky General Assembly meets on a biennial basis with a ten-day session during the interim to elect leadership, committee chairs, and appoint committee members. However, in January Governor Wallace Wilkinson included in his call legislation to resolve the Medicaid crisis. You have read about deficits and all the reasons for passage of House Bill 21, and the legislative committee report contains those details.

The Special Session required an inordinate amount of our time, and relationships became quite strained with some legislators over KMA's concern with portions of that bill and

our successful efforts to clean up sections that were unacceptable. Your Board of Trustees and leadership acted in a very statesmanlike manner and did all the right things as they represented you and your patients foremost in the deliberations. Despite the distractions and rhetoric, they never lost sight of the need, particularly, to protect indigent patients and physicians who treat the vast majority of Medicaid recipients. As you can tell, we were extremely proud of our leadership and the role they played.

Health care is the number one domestic concern today, and we can expect the 1992 Kentucky General Assembly to be the toughest we have faced. Every legislator wants to get his "star" via health care legislation. We will need the help of every Kentucky physician more than ever. Please respond to every call for action.

The major transaction in the history of KMA occurred in 1991 with the sale and move from our Headquarters Office. Ephraim McDowell Drive has been home to KMA and to me, personally, for over 30 years, and there were a lot of emotions tied to that location where so much medical history has been made, and where so many of us on staff have spent so many years of our lives. However, we had expanded the building twice, and the building was no longer suitable for KMA and KMIC. Real estate experts predicted the building's best value would be a single user with minimum retrofit. We were fortunate that Hospice of Louisville brought KMA a most attractive offer which the Board felt was fair to all concerned. KMA staff has remained at the same level for 15 years. KMIC simply needed more room, parking was at a premium, and we were unable to obtain additional parking in that location. We are very pleased and proud that another nonprofit health/medical service organization has purchased the building. The tradition lives on.

We have now moved to our new Headquarters at the Forum Office Park on Hurstbourne Parkway and at this time we are still trying to get settled in. We are extremely pleased with the park-like setting and the general location of the building. There are always some problems with a move of this magnitude but we are getting them resolved one by one. The Board has been very enthusiastic in its approach to our needs, and we look forward to a time when we can have members in for an open house to see and share our new work space. KMA's committee structure and staff activities have maintained their high level of performance and continued their excellent work despite the interruptions.

It is inappropriate to discuss KMA without highlighting the work of the Kentucky Physicians Care program. We need to recognize particularly those primary care physicians on the front lines of the program who literally make it work. I can think of no more unselfish service that a physician can provide than to participate in KPC. We are fully aware that physicians have been providing care for many years, but those physicians not presently participating should be aware that this program provides medicine an opportunity to docu-

ment the fact that Kentucky physicians have and are taking care of the poor. It gives us armament to take to Congress, the Kentucky Legislature, board rooms of major businesses, and union halls when these groups complain about the cost of medical care and point to the uninsured and indigent. While others talk about the problem, physicians, hospitals, pharmacists, dentists, and pharmaceutical companies are doing something. KMA is extremely proud this year that the Kentucky Dental Association joined with us and is providing dental care to those in need. We again thank Pfizer Pharmaceuticals for taking the lead and supporting a program to provide free pharmaceuticals to a needy group of people. Patients and KMA reap many benefits from Kentucky physicians' participation. We thank you and salute you.

We continue to work with the various allied health groups and improve our relationships. We work hand-in-glove with Kentucky Hospital Association (KHA) during the Kentucky General Assembly and the interim on matters relating to legislative and regulatory functions. The Allied Health Council is composed of KHA, Kentucky Association of Health Care Facilities (KAHCF), Kentucky Dental Association (KDA), Kentucky Pharmacists Association (KPA), and, of course, KMA. We meet periodically to discuss mutual concerns and keep each other aware of current happenings affecting our respective organizations.

Perhaps the most significant event this year, from a physician's standpoint, was HCFA's attempt to skirt Congressional authority and reduce physician payments in contrast with the law as agreed to by all parties and adopted by Congress. The American Medical Association mobilized national, state, and county societies, and specialty groups to ward off the HCFA proposal to reduce physician payment across the board (a 16% reduction was planned). Congressmen, Senators, national press, bureaucrats, and everyone involved credits the AMA for the defeat of the RBRVS reduction. Every physician and person involved in medical care, including patients, needs to be more aware that AMA carried the fight and was successful. I have never been more proud of AMA than I am at this time. It was, indeed, one of AMA's finest hours.

We are pleased to note that at the writing of this report KMA membership has already surpassed 1990 year-end figures. Although we continue to increase membership in almost every category, our percentage of the eligible physician population has declined slightly in the past year due to members who have moved out of state or have retired. Because of this, recruitment and retention efforts have already begun for the 1992 membership year and we call on the help of members throughout the state to serve as "Ambassadors-in-Membership" as we AIM for new goals in the year ahead.

KMA's financial health continues at its strongest level. We've had no dues increase the past few years, and even though we operate on a five-year plan, it should be at least another five years before any increase needs serious consid-



eration. Funds from the sale of our Headquarters Building are being put aside for future use, as we anticipate buying or building our own Headquarters again when we complete our current lease in 1996.

Operation Desert Storm was extremely difficult for 70 members and their families. We were very proud of those physicians and their families for the service they performed on behalf of our nation. Also, thanks to those physicians and families at home for their assistance and support during this trying time.

As you read the reports of the 40 to 50 committees and officers, it is important to note the work they perform on behalf of Kentucky physicians. Few people, other than those of us involved on a day-to-day basis, are aware of the numerous laws and regulations brought about by KMA committees. A substantial portion of Kentucky's health, medical, and safety laws resulted from KMA's committee work. Many things taken for granted today during the daily functions in physician's offices and hospitals are a product of KMA committees.

Your Board of Trustees, Executive Committee, and Quick Action Committee spent an inordinate amount of time (over and above usual requirement) in Louisville this year working on the Special Session, the sale of the old Headquarters building, and lease of new offices. They have willingly attended special Sunday and evening meetings at great sacrifice to their practice and personal time representing you in these momentous decisions.

We have been extremely impressed with the work of William P. VonderHaar, MD, who is serving his first year as Secretary-Treasurer. This office is not uncomplicated and requires a great deal of time, including many telephone calls and visits to the KMA office. Doctor VonderHaar has become very knowledgeable of KMA's finances and inner workings, and working with him has been a real pleasure for the staff. Cecil D. Martin, MD, Chairman of the Board, has done a superb job by keeping the flow of business going and working with the President on major events. We also look forward to working with next year's President, S. Randolph Scheen, MD. Doctor Scheen, who is in his 26th continuous year on the Board, comes well prepared for the role he assumes on October 2 after wearing the Secretary-Treasurer's hat for 24 years.

While I earlier said it was a tumultuous year, it went quite smoothly, as usual, because of a dedicated, experienced, and hard-working staff. The Headquarters Office move, taking place while we were getting prepared for the Annual Meeting, could have been disastrous. Great staff planning and implementation of that move kept us from missing a beat. I feel a special honor to have such outstanding people to work with each and every day. They do the impossible. We welcomed a new executive staff member this year as Director of Governmental Relations and Staff Counsel. Brian Brezovsky came to us from a well respected law firm and his

experience has already proven to be quite beneficial. We hope he has a great career with us.

Let me pay special tribute to Preston P. Nunnelley, MD. Doctor Nunnelley has done an outstanding job this year and has not flinched when making the hard choices. He has handled himself in a superb manner before the membership, public, and the press, and on numerous occasions has represented KMA before the Kentucky General Assembly. Preston Nunnelley has been a forceful spokesman for medicine and staff has taken great pride in his accomplishments. We look forward to seeing more of him in the coming years. Preston and Lucille Nunnelley have truly been a credit to this Association and to medicine and we thank them for their service and sacrifices.

On behalf of the KMA staff, we thank the members for the opportunity to serve and look forward with great anticipation to the coming year.

**Robert G. Cox**  
**Executive Vice President**

## Report of KMA Physicians Services, Inc

KMA Physicians Services, Inc, continues as KMA's only wholly owned subsidiary; and as a holding company, its sole subsidiary is the KMA Building Corporation.

The KMA Building Corporation was formed when we owned our Headquarters Building, and its only role was to collect rent and to pay the mortgage, taxes, insurance, and maintenance costs of the most recent addition to the building.

With the sale of the KMA Headquarters Building on Ephraim McDowell Drive, which was to be finalized on September 10, 1991, there will be no continuing active role for the Building Corporation or KMA Physician Services, Inc. Recognizing that KMA may well own another building within the next five years, both of these entities will be kept alive and available for future use as needs might indicate.

**Cecil D. Martin, MD**  
**Chairman**

## END OF CONSENT CALENDAR ITEMS

### Report of the President

I am pleased and feel privileged to submit my final report to you as 140th President to the Kentucky Medical Association. I approach the end of my term with conflicting feelings. I hope that I have made a contribution not only to the Association, but also to the profession, and hope that any goals I have accomplished are beneficial. Obviously, any accom-

plishments were made in concert with many others. I also feel a little sadness that I could not have done more and that my term as President is ending. Regardless, I intend to continue to stay involved in whatever capacity I can be of service.

I believe as firmly as ever in "Pride in Medicine." To reiterate, no other profession offers so much in terms of pure joy and sense of accomplishment. We really can do a better job of documenting and publicizing our achievements without being defensive and without being apologetic to our critics and the public at large. Our primary mission continues to be our responsibility to our patient. In spite of this, owing to negative forces growing from the government and the media, we have become victims of our own success, sometimes, in our patients' eyes. Our primary opportunity to revise this view lies in the art of our profession; that is, face-to-face contact with our patients in a caring and humane way.

I continue with an abiding concern with the Judiciary. This Associational year, the Kentucky Supreme Court found that the medical malpractice statute of limitations was unconstitutional. In 1989 this same court decided that the confidentiality of peer review law was inappropriate. There is indication that the Judiciary frequently undermines legislative intent in order to establish itself as the final arbiter not only of legal matters, but also of social issues. The only recourse that we, the public, have to this situation is to take part in judicial campaigns, as well as being more cognizant of the legislative process in general.

This year it was my pleasure to take part in two Washington-related activities on your behalf. In February, Congressman William Natcher was honored as a recipient of the AMA's Nathan Davis Award. Mr. Natcher is a valued friend of medicine and one of Congress's most powerful lawmakers. The second occasion to visit Washington occurred in association with the Washington Dinner. This biennial trip is probably more worthwhile for the accomplishments that occur intangibly. At the time of the visit, regulations were about to appear concerning the conversion factor developed by the Health Care Financing Administration for the Resource-Based Relative Value Scale. It was fortunate that the Kentucky delegation could speak to this issue at such a critical time, and our ultimate success can be partly attributed to that visit.

Another issue that has been of concern to me is our legislative involvement, not just as an organization, but more importantly, as individuals. As has been transmitted in other forums, KMA continues to face some significant issues in the state legislative arena which include mandated participation in Medicaid, hospital rate review, mandatory CME, legislation defining physicians' offices, mandatory testing for AIDS, direct billing by physician extenders, prescription privileges for nurse practitioners, and others.

We can all be justly proud of KMA's on-site legislative efforts and accomplishments. The work of our legislative

representatives, however, is obviated without campaign support from KEMPAC and from individual physicians. Currently, only 15-20% of physicians are KEMPAC members. Given the listed threats to our profession in the legislative arena, this level of physician support is simply inadequate. Unless all physicians become involved with their local legislators, and unless KEMPAC is able to maintain and increase its campaign activities, I am fearful that we are doomed to fully face all of the onerous provisions that have been suggested.

We face grave uncertainty but have never had a more timely opportunity to influence the political process. Yet, in terms of overall contributions, KEMPAC ranked eighth in 1991 in proportion to all contributors. This ranking was behind the United Auto Workers, Humana, the Mayor of Louisville, and the Kentucky Auto Dealers, among others.

I have only highlighted a few issues. There are many, many more that KMA confronts and successfully deals with, literally on a daily basis. Again, it has been my privilege to be a part of this great effort, and I feel assured that we will continue to progress and move forward under the able leadership of our incoming President, Randy Scheen. In spite of the intensive efforts of relatively few physicians, our profession cannot thrive in the current socio-political context without more participation from all physicians. I cannot sufficiently underscore the importance of this participation, nor the gratification that is available once that participation has begun.

I give all my friends and colleagues and all members my warmest good thoughts, and humbly thank you for the trust you have placed in me in allowing me to serve as your President.

**Preston P. Nunnelley, MD**  
**President**

**Recommendations, Reference Committee 1:**

Reference Committee No. 1 reviewed the Report of the President. We would like to applaud Doctor Nunnelley for this report and in particular for his efforts to emphasize pride in our profession. Reference Committee No. 1 recommends this report be adopted.

**Report of the Kentucky Physicians Care Operating Committee**

The Kentucky Physicians Care Operating Committee met twice this year with your Chairman and staff being involved in some aspect of the program on a daily basis throughout the year.

Since January 1, 1985, 85,422 individuals have been cer-



tified eligible for the Kentucky Physicians Care program and 38,416 referrals have been made, which we estimate resulted in over 153,000 physician encounters. This latter figure is estimated because, in most cases, once a patient is seen by a participating physician, he or she tends to continue seeing that physician and, as a result, does not continue to call the toll free number. New applications for certified eligible patients are received in the Headquarters Office every day.

The Headquarters Office continues to receive telephone inquiries and requests for referral, with a current average of 65 calls coming in on the toll free line daily. Over 85,864 calls have been received through the toll free number since the program began in January 1985.

The participation and support of the physicians in Kentucky continue to be excellent. Our current level of participating physicians is 2,376, representing a high percentage of the physicians who are actively practicing medicine in Kentucky. The Committee wishes to particularly recognize the continuing support of the primary care physicians who remain the initial contact point for the vast majority of referrals made through the program. The contribution made by these men and women is incalculable, and we are very appreciative of their efforts on behalf of the KPC patients and the medical profession in Kentucky.

We continue to experience problem areas around the state where more physicians are needed in the program. Letters were sent to hospital chiefs-of-staff in several counties where we need more participating physicians, and your Chairman and other members of the Committee are being invited to attend future meetings of some of these hospital medical staffs to discuss the KPC program. Contacts have also been made through phone calls and correspondence to several physicians and trustees in these problem areas encouraging participation in the program.

The Kentucky Health Care Access Foundation continues as the primary funding source for the program. The Foundation underwrites the cost of the toll free telephone lines and two full-time employees. According to the Foundation, its financial contribution since the onset of the program through March 31, 1991, totalled \$387,427.96.

KMA continues to provide space at the Headquarters Office, telephone equipment, supplies, furniture, computer time and equipment, postage, and KMA staff involvement as needed.

The Cabinet for Human Resources has continued to be extremely cooperative during the course of the project. Representatives from the Department for Social Insurance continue to work closely with KMA/KPC staff and have given a considerable amount of time and effort to the program, as have the 1,000 field workers in the 120 county CHR offices across the state.

Through the Kentucky Pharmacy Providers project, which began July 16, 1990, over 2,377 prescriptions have been filled at no charge to respective KPC patients. There

are currently 356 pharmacies throughout the state participating in the program, and we are most grateful to the Kentucky Pharmacists Association and the many pharmacists who have worked closely with KMA/KPC staff during this first year of the program's existence.

We are especially indebted to the Pfizer/Roerig Pharmaceutical Company for its generosity in making its full product line available at no charge to KPC patients during the past year. It is with much enthusiasm that we report that Pfizer/Roerig has agreed to continue that commitment through June 1992. A press conference was held on April 17 to announce this recommitment. The Committee would particularly like to thank Charles L. Hardwick, Vice President for Civic Information, Pfizer Corporation, and Deborah Smith-Callahan, RN, Government Relations Manager for Pfizer, for their continuing support of the Kentucky Pharmacy Providers program and their extraordinary efforts and cooperation in working with KMA and the Foundation during this past year.

Approximately 25 other major pharmaceutical companies were invited to send a representative to a luncheon meeting on April 17 at the Lieutenant Governor's mansion. The Kentucky Pharmacy Providers program and Pfizer's participation were discussed at the meeting and those pharmaceutical companies in attendance were asked to participate in the program as well.

Kentucky, through the Kentucky Physicians Care Program, continues to receive national recognition for this unique program, and Kentucky's medical profession is viewed by its peers as an active, progressive leader in dealing with the issue of indigent care.

KMA was recently chosen as one of 47 Certificate of Excellence winners in the American Society of Association Executives (ASAE) Advance America Awards Program. The awards will be presented at the ASAE Annual Meeting ceremonies scheduled for August 14 in Washington, DC.

In a letter from R. William Taylor, ASAE President, it was noted that, "Your Kentucky Physicians Care program truly embodies the spirit of the Associations Advance America campaign to showcase the many things associations are doing to make this country a better place in which to live. As President Bush as said, 'There is no problem in America that is not being solved somewhere.' You have shown that this is especially true among associations."

The Committee believes that the Kentucky Physicians Care program has played a role in demonstrating the needs of the medically indigent in Kentucky and the fact that the voluntary private sector is working to address those needs.

The Committee feels there are advantages to the program being on a temporary yearly renewal basis, and therefore, suggests that KMA continue the Kentucky Physicians Care program through December 31, 1992, contingent on:

1. Program funding being continued, as appropriate, by the Kentucky Health Care Access Foundation, with KMA contributing in-kind services as done in 1985, 1986, 1987, 1988,



1989, 1990, and 1991;

2. A continuing commitment from the Cabinet for Human Resources to evaluate program applicants for eligibility, as is currently being done;
3. The Kentucky Hospital Association continuing its Fair Share program as currently operated;
4. The Kentucky Health Care Access Foundation continuing to vigorously encourage the active participation of all other health care delivery and/or financing organizations in Kentucky Physicians Care or the Fair Share program, as may be appropriate; and
5. The Kentucky Health Care Access Foundation making Kentucky legislators aware of the plight of those ineligible for Medicaid assistance solely because they do not meet the confusing and arbitrary requirements of the Medicaid program, while working to broaden the societal financial obligation necessary to provide care to those in need of such assistance.

As Chairman, I am most grateful to the many individuals and organizations that make this most significant program possible.

**Russell L. Travis, MD  
Chairman**

## RECOMMENDATIONS

1. The Committee recommends that KMA continue the Kentucky Physicians Care program through December 31, 1992, contingent on:
  - A. Program funding being continued, as appropriate by the Kentucky Health Care Access Foundation, with KMA contributing in-kind services as done in 1985, 1986, 1987, 1988, 1989, 1990, and 1991;
  - B. A continuing commitment from the Cabinet for Human Resources to evaluate program applicants for eligibility, as is currently being done;
  - C. The Kentucky Hospital Association continuing its Fair Share program as currently operated;
  - D. The Kentucky Health Care Access Foundation continuing to vigorously encourage the active participation of all other health care delivery and/or financing organizations in Kentucky Physicians Care or the Fair Share program, as may be appropriate; and
  - E. The Kentucky Health Care Access Foundation making Kentucky legislators aware of the plight of those ineligible for Medicaid assistance solely because they do not meet the confusing and arbitrary requirements of the Medicaid program, while working to broaden the societal financial obligation necessary to provide care to those in need of such assistance.

## Recommendations, Reference Committee 1:

The Reference Committee reviewed the report of the Ken-

tucky Physicians Care Operating Committee. We would like to thank Doctor Travis for his detailed report and his efforts on behalf of the Committee. The Committee continues to garner well deserved recognition and awards and the report reiterates continuance of the committee's work. The Reference Committee recommends this report be adopted.

## Report of Kentucky Medical Insurance Company

Your company has experienced another important year of development — a year filled with change directed at posturing us for the future.

Some of the more visible changes are in the leadership at Kentucky Medical. This is my first time to report to you since I was elected Kentucky Medical's Chairman when Ballard "Hop" Cassidy retired from the Board of Directors earlier this year. Hop had been Kentucky Medical's only chairman through its first 13 years. His leadership will certainly be missed. Don Barton, MD, was elected to fill the Board vacancy created by Hop's retirement.

Kentucky Medical also has a new President and Chief Executive Officer, Steven L. Salman, who comes to us from Cincinnati-based Sisters of Charity where he, among other responsibilities, served as President and Chief Executive Officer of the MSJ Insurance Company of Denver, Colorado, and founded and served as Chairman of Preferred Physicians Insurance Company of Omaha, Nebraska, a physician insurer licensed in 32 states. Steve replaces Carl L. Wedekind, Jr, the only president and chief executive officer Kentucky Medical has ever known. Carl, who currently serves as advisor to the President, will retire at the end of 1991.

Kentucky Medical's Board recently held its annual Think Tank meeting. This year's meeting focused on changes in the health care delivery system over the next five years and how Kentucky Medical will respond. As a result of this meeting and Salman's new leadership, you will undoubtedly be hearing more about Kentucky Medical's future role in the health-care delivery system.

Market competition has continued to be fierce. Predatory pricing tactics designed to gain market share — without regard to actual claims costs — continue to be used by some of our competitors. In our customary fashion, we have responded by passing along to our policyholders savings that materialize from *real* claims costs savings.

During 1991 such savings were passed along in the form of additional premium credits. Our credit for good claims experience was expanded to 25% from 10%. Our Physicians Experience Pool (PEP) credit remained unchanged at 12%. Credit for attending our claims prevention seminar remained unchanged at 5%. We expanded our parameters so that attendance at a more comprehensive program introduced this year qualifies our policyholders for the credit for two consecutive years. Although our base rates remained unchanged in



1991, an average policyholder's premiums were reduced by 13% as a result of premium credits.

Despite competitive pressures, Kentucky Medical continued to operate in a responsible manner that yielded positive results. Our defense team won 90% of the cases that went to trial last year, bringing our winning case ratio to 84% from 1980 through 1990. Although our number of policyholders is down slightly from a year ago, Kentucky physicians continue to rely on Kentucky Medical as a source of protection against suits, through our claims prevention and risk management programs, and for a rigorous defense when faced with a malpractice claim.

Our financial base continues to be strong, with over \$37 million set aside to pay future claims costs and a safety net (surplus) of more than \$18 million to provide our policyholders the protection they deserve should the malpractice climate deteriorate significantly.

Kentucky Medical continues to be a very important part of KMA because of the role we play in stabilizing and bringing competition into the medical professional liability market for Kentucky physicians; this is the reason you formed Kentucky Medical. Our responsible operating style is challenged, however, by companies who entered the Kentucky market after the last malpractice crisis ended. These companies can, and undoubtedly will, abandon the state once the next crisis begins.

We are already seeing clear evidence that the encouraging drop in the number of claims over the past five years has ended, and the frequency of claims has begun its upward spiral. The average cost of settling claims continues its uninterrupted rise.

We have met our founding challenge and will continue to do so in the future, but as in the past, we need your support. Kentucky Medical, KMA, and Kentucky physicians must look beyond today and focus on Kentucky physicians' need for a long-term, stable source of medical liability protection. Kentucky Medical is here for the long term. We are positioned to withstand the difficult times ahead and will remain steadfast in protecting Kentucky physicians. With your support, Kentucky Medical will continue to be what KMA formed it as — a shield of protection for Kentucky physicians.

**Richard F. Hench, MD**  
**Chairman, Board of Directors**

## **Recommendations, Reference Committee 1:**

The Reference Committee reviewed the Report of the Kentucky Medical Insurance Company. It was noted that KMIC continues to prosper and grow. We thank the Chairman of the Board and Doctor Hench for his leadership and detailed report. The Reference Committee recommends that this report be filed.

## **Resolution I**

### **Physicians Serving in Desert Storm Operation Warren County Medical Society**

WHEREAS, over 70 members of KMA were called to active duty during the Desert Storm crisis; and

WHEREAS, the KMA recognizes the personal and financial hardship imposed upon members who sacrificed so much during the crisis; now therefore be it

RESOLVED, that the 1991 KMA House of Delegates recognizes the 70 members who so bravely and graciously served their nation during a time of international crisis; and be it further

RESOLVED, that the House of Delegates honor those members who fulfilled their duty in the highest tradition of Kentucky medicine, and be it further

RESOLVED, that each KMA member who served receive a copy of this Resolution, and that the Resolution become a permanent part of the record of this organization.

## **Recommendations, Reference Committee 1:**

The Reference Committee reviewed Resolution I, Physicians Serving in Desert Storm Operation submitted by Warren County Medical Society. We proudly support this Resolution which recognizes the patriotism of our medical military personnel from Kentucky and recommend this Resolution be adopted.

Mr Speaker, Reference Committee No. 1 recommends the adoption of this report as a whole, as amended.

Mr Speaker, I would like to thank all of the members of Reference Committee No. 1 for their time and effort in reviewing these reports and Resolutions.

Other members of this Committee are Jane R. Bramham, MD, Bowling Green; Donald E. Brown, MD, Somerset; Howard B. McWhorter, MD, Ashland; and H. Michael Oghia, MD, Russell Springs. I also wish to thank Theresa Wilson for her help and guidance in preparation of this report.

**Respectfully submitted,**  
**REFERENCE COMMITTEE NO. 1**

**Ralph D. Caldrony, MD, Lexington, Chairman**  
**Jane R. Bramham, MD, Bowling Green**  
**Donald E. Brown, MD, Somerset**  
**Howard B. McWhorter, MD, Ashland**  
**H. Michael Oghia, MD, Russell Springs**

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*Editorial Note: Unless otherwise noted, the Reference Committee action on each Report and Resolution was accepted as printed. Any opposing action taken is stated in discussion following the item.*

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REPORT OF REFERENCE COMMITTEE NO. 2

Harry W. Carter, MD, Ft. Mitchell, Chairman

- 13. Report of the Scientific Program Committee
- 14. Report of the Scientific Exhibits Committee
- 15. Report of the Continuing Medical Education Committee
- 16. Report of the Council for Continuing Medical Education
- 17. Report of the Cancer Committee
- 18. Report of the Physician Manpower Committee
- 19. Report of the Hospital Medical Staff Section
  - Resolution B — Substance Abuse Testing: A Must for Kentucky Medicine (McCracken County Medical Society)
  - Resolution C — Economic Credentialing: Stop It Now (McCracken County Medical Society)
  - Resolution D — Kentucky Model Medical Staff Bylaws (McCracken County Medical Society)
  - Resolution E — Access to Tobacco by Children (Pulaski County Medical Society)
  - Resolution K — Eliminating Access to Tobacco by Children (Fayette County Medical Society)
  - Resolution CC — Kentucky Model Medical Staff Bylaws (Board of Trustees)
  - Resolution DD — Economic Credentialing (Board of Trustees)
  - Resolution FF — Radon Exposure (Board of Trustees)

ITEMS FOR CONSENT

Reference Committee No. 2 reviewed the following items and recommends they be filed or adopted, as indicated, by consent of the House, without discussion:

- 14. Report of the Scientific Exhibits Committee — filed
  - 16. Report of the Council for Continuing Medical Education — filed
  - 18. Report of the Physician Manpower Committee — filed
- Mr Speaker, Reference Committee No. 2 recommends adoption of the Consent Calendar as a whole.

Report of the Scientific Exhibits Committee

The Scientific Exhibits Committee does not meet formally. Its activities are carried out by mail and telephone. We notify members through the *Journal of the KMA* and the "Communicator" of the availability of space and provide applications to interested individuals. In addition, we also provide exhibit space for organizations such as the Impaired Physicians Committee and the Cabinet for Human Resources. In 1990, we had 12 exhibitors. All of the designated space was filled and a waiting list resulted. We wish to express our appreciation

to the following exhibitors at the 1990 Annual Meeting:

- Update in use of MRI in Oncology
  - Baby Jose, MD
- Wound Irrigation for Dupuytren's Contracture
  - Morton L. Kasdan, MD, FACS
- Resection Arthroplasty for Trapezium Metacarpal
  - Morton L. Kasdan, MD, FACS
- Acquired Immune Deficiency Syndrome (AIDS) and the Eye
  - Charles F. Mahl, MD
  - Steven M. Bloom, MD
- A Model of Etiology in Craniomandibular Disorders
  - John D. Tarrant, DMD
- Staged Soft Tissue Reconstruction with the Antibiotic Bead Pouch
  - Stephen L. Henry, MD
- Radiation Oncology in Cancer Management
  - Kentucky Radiation Oncology Society
- Continuing Medical Education — Kentucky Style
  - University of Kentucky College of Medicine
  - Office of Continuing Medical Education
- Help Gain Control of Diabetes
  - American Diabetes Association
  - Kentucky Affiliate
- Vital Statistics
  - Cabinet for Human Resources
- Kentucky Cancer Program

I want to take this opportunity to thank the members of the Committee for serving. The Scientific Exhibits area adds tremendously to the overall success of the Annual Meeting and remains an integral part of the activities and the dissemination of information and science.

Richard A. Kielar, MD  
Chairman

Report of Council for Continuing Medical Education

The Council on Continuing Medical Education acts as the provider of CME for the Association. The main educational opportunity offered is the Annual Scientific Program. In January, the Council met jointly with the CME Committee. The purpose of the joint meeting was to refamiliarize all members with the Essentials of CME which describes the process and organization of all CME efforts as directed by the Accreditation Council on Continuing Medical Education (ACCME). This document is the basis of all sponsored CME programs throughout the country. Although it is revised periodically, its basics remain the same, but refamiliarization was felt to be appropriate as well as helpful to new Council members. Following the joint meeting, a separate meeting was held to discuss specific Council items. Of most significance,



it was noted that the KMA's provider status was subject for resurvey by the ACCME. The survey was scheduled for June 7 in Chicago and would constitute a reverse site survey.

In preparation for the reverse site survey, results of the previous survey were considered and actions to resolve discrepancies were noted. This information, together with a description of other efforts the Council had taken to refine the provider process, were included, and staff met with a three-member team of the ACCME in Chicago to defend the application. It was noted that additional work on developing and stating CME objectives for each course was appropriate, that CME needs assessment should be related more closely to the development of goals, and that better coordination between the Council and the Annual Meeting Scientific Program Committee was necessary. On balance, the reverse survey was beneficial and informative to the Chairman and staff, as well as to the ACCME team members. Subsequent to the survey, the Council was notified in the early part of July that continuing accreditation had been approved for a period of four years.

As a provider, the Council is authorized to jointly sponsor CME efforts with nonaccredited organizations, but the Council adopted the tacit position that joint sponsorship activities would generally be avoided. It was felt that the purpose of the overall CME program was for local groups and institutions to become self-accrediting.

During the coming year, the Council hopes to refine its activities in keeping with comments provided by the ACCME on the survey application. Some of these activities will include closer input into the development of the Annual Scientific Program, working more closely with specialty groups on needs assessment, evaluating the activities of CME programs, and consideration of joint sponsorship activities.

**W. David Hager, MD**  
**Chairman**

## Report of the Physician Manpower Committee

The focus of the efforts of the Committee on Physician Manpower this year was directed toward physician maldistribution. Previously, national reports had predicted that there would be an excess of physicians by the year 2000. In 1987, there were 200 physicians per 100,000 population and that number was expected to increase to 239 per 100,000 nationwide. In 1987, Kentucky had 159 physicians per 100,000. Based on national figures Kentucky obviously did not have an excess of physicians nor do experts in the field expect that an excess will ever be a problem. Kentucky's difficulty was and will likely continue to be a problem of maldistribution. Kentucky is currently the sixth most underserved state by rural physicians.

A review of current literature, including that produced

by the AMA Council on Medical Education, indicates that the most important issue affecting rural shortages are lower reimbursement rates; liability premiums; professional isolation; lack of support equipment and staff; insufficient population and economic base; lack of cultural life; poor educational opportunities for children; spouse dissatisfaction and lack of job opportunities for spouses; heavy workload and lack of relief for cross coverage; and severe financial problems of rural hospitals.

Concomitantly, those factors that assist in recruiting physicians to rural areas are rural rotations and electives for medical students and residents, the selection of applicants from rural areas, and the provision of continuity experiences in rural health throughout graduate and undergraduate education.

In approaching and analyzing this area, the Committee was fortunate to have input and assistance from the deans of both medical schools, the area health education centers, and the Department for Health Services Resources (Cabinet for Human Resources). All of these organizations, together with KMA, have similar goals.

An effort that the Committee has undertaken and hopes to finalize beginning with the new school year commencing in the fall is to arrange for medical students or residents to visit high schools they attended accompanied by an area physician to provide information and relate personal experiences to high school students. Several medical students have already been identified who have agreed to become involved in this effort.

This recruitment activity, it is felt, will be most productively directed toward freshmen and sophomore high school students. An area of focus will be financial assistance which is available from a variety of resources and this information may be generally unknown to aspiring medical school applicants. Other efforts of like nature will be undertaken by the organizations already mentioned.

It is the feeling of the Committee that resolution of the distribution problems will take the concerted efforts of all the organizations involved. It is the Committee's intent to further pursue these activities from both the perspective of practical efforts such as the school visits, and from a philosophical standpoint with attention directed to rural primary care physicians.

**Robert R. Goodin, MD**  
**Chairman**

## END OF CONSENT CALENDAR ITEMS

## Report of the Scientific Program Committee

"PREVENTION: Rx for Health Care in the 90s" was selected

by the Scientific Program Committee as the overall theme for the 1991 KMA Annual Meeting Scientific Program. Each morning session will focus on the theme from the perspective of the various specialties participating in the Meeting. The Committee members and representatives from the 23 specialty societies have worked hard to bring some of this country's outstanding speakers to the Meeting, and it is hoped that the membership will find their presentations useful.

The Scientific Program was planned last fall and a meeting was held in December with the presidents and/or representatives of the 23 specialty groups that will participate in the annual session. Afternoon specialty groups' scientific programs held in conjunction with the morning general sessions have proven invaluable, and provide an excellent contribution to the continuing medical education of the membership. I personally appreciate the excellent cooperation the Committee has had from the specialty societies in planning the overall Meeting, and I thank them for their suggestions and assistance.

In September 1990, KMA's Annual Meeting was held, for the first time, at the Hyatt Regency Hotel/Commonwealth Convention Center in Louisville. Feedback on the facility was very positive and attendance at the 1990 Meeting was higher than it has been in the last ten years. This was an excellent facility and will be the site of the 1992, 1993, and 1994 KMA Annual Meetings.

The 1991 KMA Annual Meeting will be held at the Hyatt Regency Hotel/Lexington Center in Lexington. Meetings of the KMA Board of Trustees, House of Delegates, Reference Committees, KEMPAC, and Auxiliary, as well as various food functions will be held in the Hyatt Regency Hotel. General registration, specialty group meetings, general sessions, and the technical exhibit hall will be located in the Lexington Center. We urge members and their staffs to visit the exhibits, which offer opportunities to discuss new products and become familiar with new equipment free from the interruptions or distractions of the office or hospital.

The scientific sessions are again accredited for AMA Category I continuing medical education credit and are also approved for CME credit by several specialty societies, including the American Academy of Family Physicians.

Over the past few years, KMA has received an increasing number of requests for specialty groups to hold meetings in connection with the KMA Annual Meeting and for KMA to sponsor an out-of-state guest speaker.

The Scientific Program Committee was asked to develop a method to deal with these requests. The Committee felt that since KMA was the major financial underwriter for out-of-state guest speakers, in order for a specialty group to receive speaker sponsorship, either a significant number of its members must be KMA members as well, or a significant percentage of its members must attend and participate in the KMA Annual Meeting. The question to be determined is, "what is significant?"

In 1990, when we categorized Annual Meeting registration by specialties, the average number of any specialty was 41, with a range of 14 to 148. We calculated the percentage of a given specialty registering from the statewide census of that specialty. That ranged from 6% to 50% with an average of 20%. We took the entire active KMA membership and determined what percentage of each specialty group was represented in KMA. The average was 74%, with ranges of 39% to 91%.

Finally, we determined the total number of KMA's active membership by specialty. The average was 142, with a range of 31 to 690.

Our recommendation was that specialty societies meeting the following four criteria would be provided meeting space for an afternoon specialty group meeting during the convention:

1. Specialty groups must have a national or parent organization.
2. Specialty groups, to be recognized, are not required to have a separate and distinct certifying Board.
3. The state society applying for recognition must first have formal affiliation with its national counterpart.
4. A specialty group must be a primary specialty or "major" subspecialty in terms of delineated scientific knowledge within the realm of the discipline of medicine.

KMA will provide space, help promote attendance at the meeting, and furnish some limited visual aids equipment at no charge to those specialty groups meeting the above four criteria that wish to participate in the meeting. The location and day of the meeting will be determined by the Program Committee.

Those specialty groups that meet the preceding four criteria and also meet two of the four following requirements will be eligible to have KMA underwrite the expense of an out-of-state physician speaker to address the General Sessions Program and the afternoon specialty group meeting of the sponsoring society:

- A. Must have a minimum of 41 attendees register at the KMA Annual Meeting.
- B. Must have a minimum of 20% of its specialists in Kentucky register at the KMA Annual Meeting.
- C. Must have a minimum of 74% of the specialists holding KMA Active membership.
- D. Must have a minimum of 142 KMA Active members.

The KMA Executive Committee adopted this concept as KMA policy to take effect with the 1992 KMA Annual Meeting. Therefore, plans for the 1992 meeting will be based on attendance and membership at the end of 1991. A mailing was sent to all specialty group presidents in May of this year notifying them of this policy.

I am very grateful for the efforts of those who have assisted in the formation of the program, particularly the Program Committee, specialty group presidents, and program chairmen.



Suggestions for future programs are always welcomed by the Scientific Program Committee.

**Sonia R. Teller, MD, PhD**  
**Chairman**

## **Recommendations, Reference Committee 2:**

Reference Committee No. 2 reviewed the Report of the Scientific Program Committee and recommends it be filed.

Reference Committee No. 2 would also recommend re-evaluating the criteria for eligibility to have KMA underwrite the expense of an out-of-state physician speaker, and would recommend that smaller societies be allowed to jointly sponsor a speaker or provide a speaker at their own expense.

## **Report of the Continuing Medical Education Committee**

The Committee on Continuing Medical Education has enjoyed a busy year, even though the Committee has formally met on only two occasions.

The first meeting was held jointly with the CME Council, where the Essentials for Continuing Medical Education were reviewed. The main thrust of the Committee this year has been resurvey of six institutions which had previously been accredited by the Committee. The Committee serves as the accreditation arm of KMA's CME efforts. In this role the Committee surveys, accredits, and monitors hospitals and other facilities which then conduct their own singular CME programs.

At the initial meeting, survey teams were appointed for six institutions which had reapplied for accreditation. Each survey team consists of two members of either the CME Committee or Council and one staff person. Once the team is appointed, individual institutions are contacted to determine mutually convenient dates when local CME programs are being offered.

The survey team first reviews the application; then conducts a survey to review the application's contents; and finally formulates a report with accrediting recommendations, which is then voted on by the whole Committee. During the year one new application was submitted and a survey of this submitting institution will be accomplished prior to the Annual Meeting.

Interim reports from two other institutions were considered by the Committee. A portion of the accreditation process requires that accrediting facilities submit annual interim reports between surveys as a method of monitoring their activities. Generally, full accrediting of an institution is granted for a period of two years.

The Committee continued its annual solicitation for

nominees for the Educational Achievement Award. Nominations were received and a candidate was selected by the Committee, based on secret ballots. The award is given each year to an individual who has made significant contributions in medical or medically related education. Contributions in all areas of teaching, research, clinical application of medical practice, and/or patient education are considered.

The Committee noted two new developments relating to the CME accreditation process this year that were generated at the national level. First, the Accreditation Council on Continuing Medical Education (ACCME) developed guidelines for financial support of CME efforts by outside entities. This issue has been a matter of some discussion nationally. The guidelines generally require that such support be acknowledged, but not influence the method or content of the program.

The second matter noted was a change in the designation of Category 2 credit by the AMA for its Physician Recognition Award. Previously, physicians could claim all credits for the award (150 hours) in Category 1 (CME efforts sponsored by an accredited institution), and other hours in four other categories not offered by an accredited institution. Beginning in 1993, 90 hours of Category 2 credit will have to be earned in addition to 60 Category 1 hours over a three-year period. Category 2 is self-directed learning efforts. All other categories have been eliminated.

The Committee undertook this year to enhance its needs assessment capabilities. A statewide needs assessment survey will be conducted next year cooperatively by the Committee; the CME departments of the University of Louisville and the University of Kentucky; the two Area Health Education Centers; and the Board of Medical Licensure, with financial support by the Upjohn Company. Approval has been granted by the Licensure Board to include the survey in next year's annual registration, and it is anticipated that the survey will provide valuable information on empirical CME needs of physicians.

A debt of thanks is owed to Charles M. Brohm, MD, who served as acting Chairman of the Committee due to the Chairman's absence in Operation Desert Storm.

**Larry P. Griffin, MD**  
**Chairman**

## **Recommendations, Reference Committee 2:**

Reference Committee No. 2 next reviewed the Report of the Continuing Medical Education Committee, and would like to emphasize that in 1993 the categories and credit hour requirements for the AMA Physician Recognition Award will change and should be evaluated by members.

Reference Committee No. 2 recommends that Report No. 15 be filed.

# Report of the Cancer Committee

The Committee met on one occasion this year to review various activities in the field of cancer treatment and research. Gilbert Friedell, MD, explained the implementation of the Kentucky Cancer Registry directed under Senate Bill 41, adopted by the 1990 Kentucky General Assembly, which became effective July 1, 1990. The Registry is housed at Markey Cancer Center in Lexington and receives its data from Kentucky's 113 hospitals. Three employees collect the data, which will be used to enhance medical care given to Kentucky's cancer patients. Doctor Friedell will be submitting an article to the *Journal* on the Registry.

The Cabinet for Human Resource's (CHR) proposal to increase screening for breast and cervical cancer for low income women was discussed. The KMA Board of Trustees endorsed CHR's application for additional funding in this area. The increased funding will provide for outpatient follow-up care for the first time. The Kentucky Cancer Registry will also be providing physicians data on these incidences in their areas with the goal of decreasing mortality rates. As inpatient care will not be provided under this grant, CHR is making an effort to involve private physicians in the screening programs.

An article published in the *Wall Street Journal* on the fate of the indigent cancer patient and the importance of breast and cervical cancer screening was distributed. The Committee will be submitting similar articles to the *Courier-Journal*, *Lexington Herald*, and the Paducah newspaper for educational purposes and to stress the need for Kentucky to increase screening.

In August 1990 the KMA Cancer Committee conducted a random survey of KMA members relating to tobacco. The survey was mailed to 521 individuals, or one out of every seven members. The Committee received 391 responses. Following are the results:

- 1. Do you use tobacco products?  
27 — yes  
292 — no
- 2. Is your office smoke-free?  
239 — yes  
65 — no
- 3. Do you favor smoke-free hospitals or a policy for smoke-free hospitals?  
288 — yes  
21 — no

The Cancer Committee has recommended to the Board of Trustees that the results of the 1990 Smoking Survey be communicated to the membership of the Kentucky Medical Association through a "Communicator" or *Journal* article.

Accreditation by JCAH will require hospitals to be smoke-free in the future.

Activities of the Tobacco-Free Young Kentuckians Coalition were discussed along with possible legislation regarding tobacco. KMA is presently represented in the coalition by Joe Weigel, MD, Somerset.

The Committee reviewed the breast cancer options booklet provided by CHR for physicians' offices and the possibility of having the information made into a videotape. The Committee recommends that CHR consider producing the booklet as a videotape for either distribution to cancer patients or availability to physicians' offices.

The Committee plans an additional meeting during the Associational year and looks forward to expanded activity in 1991-92.

**Clinton C. Cook, III, MD**  
**Chairman**

## RECOMMENDATIONS:

- 1. The Cancer Committee recommends that CHR consider producing the breast cancer options booklet as a videotape for either distribution to cancer patients or availability to physicians' offices.

## Recommendations, Reference Committee 2:

Reference Committee No. 2 reviewed the Report of the Cancer Committee and recommends the adoption of the Report and its Recommendation.

In discussion, it was noted that a booklet is currently available through the Cabinet for Human Resources. Also available is a videotape entitled "Breast Cancer Treatment Options: Choosing What is Right For You," produced by Terry Green, RN, who is affiliated with Hospice in Fayette County.

Reference Committee No. 2 would therefore recommend that CHR also consider the alternative of obtaining an appropriate booklet and/or videotape from available sources.

## Report of the Hospital Medical Staff Section

The Hospital Medical Staff Section (HMSS), established in 1984 to provide a forum for discussion of mutual problems of hospital medical staffs, continues to see increased participation by hospital medical staff representatives in activities of the Section.

The Steering Committee met in May to plan this year's Section Meeting for August 29. The Steering Committee works toward planning educational programs each year that will include information for physicians that is vital to their individual practices and their function as members of the medical staff of their hospitals.

We believe an excellent program has been planned for



the 1991 HMSS Annual Meeting to include information on the transition to a new Medicare payment system structured on a Resource-Based Relative Value Scale (RBRVS), scheduled to begin January 1, 1992. There will be presentations on Economic Credentialing and Criminal Prosecution of Malpractice Cases, both of which seem to be causing growing concern among the medical profession. Sentinel Medical Review's "Fourth Scope of Work," scheduled to begin September 1, 1991, will also be discussed. Other topics included on the program will be Providers with HIV/AIDS — A New Dilemma; Kentucky's new Utilization Review Regulations and Potential Liability in UR; and the Patient Self-Determination Act, to include Advanced Directives.

During the business portion of the HMSS Annual Meeting, two positions on the Steering Committee are to be filled by election. The HMSS Nominating Committee has proposed the name of William Pratt, MD, London, for election to the position of Delegate. Proposed for the position of Alternate Delegate is John D. O'Brien, MD, Louisville.

Nominations will also be accepted from the floor, and both positions are for three-year terms. Steering Committee members holding other positions will remain on the Committee filling unexpired terms.

The Steering Committee would like to thank John J. Buchino, MD, Louisville, Chairman, and the other members of the 1990-91 HMSS Nominating Committee, for their dedicated work in selecting candidates for these positions. Other members of the Nominating Committee were Kenneth E. Green, MD, Leitchfield; Steve S. Kraman, MD, Lexington; H. Michael Oghia, MD, Columbia; and James T. Ramsey, MD, Frankfort.

Names being proposed by the Steering Committee for election by the Section as the 1991-92 HMSS Nominating Committee are: Steve S. Kraman, MD, Lexington, Chairman; Chris McCoy, MD, Owensboro; William Mitchell, MD, Richmond; William Pratt, MD, London; and Alfred Thompson, Jr, MD, Louisville.

Several KMA-HMSS members attended the annual meeting of the AMA Hospital Medical Staff Section and the AMA Annual Meeting in Chicago in June of this year. The following were among the large number of issues debated by the HMSS in Chicago:

Opposition to excessive and unnecessary requests for additional information and unexplained delays in processing and payment by third party insurance carriers where a completed standard claim form for reimbursement has been submitted;

Development and implementation by Medicare carriers of a mechanism to make interim payments to physicians on a temporary basis when they are unable to process a substantial fraction of Medicare Part B claims for physicians;

Opposition to any effort by Medicare or any other third-party payer to limit payment for medically necessary care, especially in the area of assistants at surgery;

Opposition to the inclusion of diagnostic services performed within three days prior to hospital admission in the Diagnostic Related Groups inpatient claims, as required in the Omnibus Budget Reconciliation Act of 1990;

Discouragement of the use of any PRO data by any hospital, medical staff, or other body for credentialing purposes;

Opposition to the use of economic criteria not related to quality to determine an individual physician's qualifications for granting or renewing medical staff membership or privileges;

Granting of clinical privileges to physicians pursuant only to the policies and procedures of the medical staff bylaws;

Allowing a physician, at the time he or she notifies the Data Bank of a dispute, to attach an explanation or statement to the disputed report;

Right of physicians to submit claims manually;

Development and implementation of a quality assurance plan for peer review organization physician reviewers;

Adoption of routine HIV testing by hospitals, clinics, and physicians based on their local circumstances;

Inclusion of appropriately modified informed consent and modified pre-test and post-test counseling procedures in routine HIV testing; and

Establishment of general guidelines for the expert witness in medical malpractice cases which should include, but not be limited to, the expert witness being licensed in the same jurisdiction and being of the same specialty as the physician on trial and the expert witness being in the active practice of medicine for at least 50% of the time, as well as methods to ensure ultimate accountability for their testimony.

As Chairman of the KMA Hospital Medical Staff Section, I would like to take this opportunity to express appreciation to the medical staffs and Section representatives of those hospitals who have chosen to participate in the KMA-HMSS. I am also grateful for the dedication of the members of the 1990-91 Steering Committee for their efforts to make the HMSS an effective KMA activity. Those members are Earl P. Oliver, MD, Scottsville, Vice Chairman; Rex Cox, MD, Louisville, Secretary; David R. Watkins, MD, Louisville, Delegate; Harold L. Bushey, MD, Barbourville, Alternate Delegate; and Robert Emslie, MD, Bowling Green, and William O'Bryan, MD, Owensboro, Members at Large.

We will continue working toward our goal of having active participation from the medical staff of each eligible hospital in Kentucky. This is a positive step toward assuring good working relationships between physicians and hospitals, and I urge each physician to see that the medical staff or his or her hospital becomes actively involved in the HMSS and all KMA activities.

**Donald J. Swikert, MD**  
**Chairman**

**Recommendations, Reference Committee 2:**

Reference Committee No. 2 reviewed the Report of the Hospital Medical Staff Section and would like to join the Section Chairman, Doctor Swikert, in encouraging all hospital medical staffs to choose a representative to actively participate in the HMSS and all KMA and AMA activities. It was noted that 90% of all Resolutions submitted by the Hospital Medical Section are adopted by the AMA House of Delegates.

Reference Committee No. 2 recommends that Report No. 19 be filed.

**Resolution B**

**Substance Abuse Testing: A Must for Kentucky Medicine  
McCracken County Medical Society**

WHEREAS, Kentucky physicians are facing an ever-growing incidence of substance abuse by health care workers in this great Commonwealth; and

WHEREAS, Kentucky hospitals are reluctant, due to lack of physician support, to require and enforce substance abuse testing for hospital employees; and

WHEREAS, the Kentucky Medical Association must continue to provide unselfish leadership in an effort to regain lost public confidence in medicine, *no matter* how controversial and unpleasant to the membership; and

WHEREAS, the physician substance abuse programs of the Kentucky Medical Association are excellent, yet they do not protect the public from ongoing substance abuse by unrecognized or "closet" substance abusers in the health care industry; now therefore be it

RESOLVED, that the Kentucky Medical Association inform Kentucky hospital medical staffs through its Hospital Medical Staff Section that the protection of Kentucky patients is a priority of such utmost importance that all physicians in this great Commonwealth should promote interval substance testing as a requirement for hospital medical staff privileges and licensure.

**Recommendations, Reference Committee 2:**

Reference Committee No. 2 next considered Resolution B — Substance Abuse Testing: A Must for Kentucky Medicine, introduced by the McCracken County Medical Society.

Reference Committee No. 2 recommends that Resolution B not be adopted.

**Resolution C**

**Economic Credentialing: Stop It Now  
McCracken County Medical Society**

WHEREAS, hospitals in this great Commonwealth are

now using a new weapon to achieve institutional cost control over independent Kentucky practitioners by denying these physicians access to the hospital; and

WHEREAS, a hospital using economic instead of quality of care factors to limit Kentucky physicians' clinical privileges is tantamount to ethical heresy; and

WHEREAS, Howard L. Lang, MD, Chairman of the Hospital Medical Staff Section of the AMA and President-Elect of the California Medical Association, defines economic credentialing as "the process of evaluating an individual's qualifications for the granting or renewal of medical staff membership or privileges based on economic factors that are unrelated to quality of care or competency considerations;" and

- WHEREAS, economic credentialing takes three forms:
- A. The hospital uses exclusive contracts for all services (surgery, internal medicine, OB-GYN, etc.) thereby bypassing the medical staff peer review process under the guise of "improved hospital efficiency;"
  - B. The hospital uses computer-collected economic performance criteria in the appointment and reappointment process, not at the medical staff level, but at the board level.
  - C. The hospital closes a medical staff department or division ostensibly for quality reasons, but, in reality, for the purpose of the hospital's bottom line; and

WHEREAS, the Florida Medical Association has sponsored Florida state law (Fla. Stat. Ann. 395.011 [Harrison Supp. 1989]; see 395.0015) which limits medical staff credentialing *only* to Florida medical staffs; and

WHEREAS, physician rights are being challenged by overly zealous "profit above all else" boards and hospital administrations, who continue to place quality medical care lower on their priority list; now therefore be it

RESOLVED, that the KMA evaluate other state statutes that allow *only* physicians the right to credential physicians; and be it further

RESOLVED, that the KMA alert its membership to economic credentialing and its effect on the limitation of physician practice rights.

**Resolution DD**

**Economic Credentialing  
Board of Trustees**

WHEREAS, hospitals throughout Kentucky are using economic credentialing to achieve institutional cost controls over independent Kentucky practitioners; and

WHEREAS, Howard L. Lang, MD, Chairman of the Hospital Medical Staff Section of the AMA and President-Elect of the California Medical Association, defines economic credentialing as "the process of evaluating an individual's qualifications for the granting or renewal of medical staff member-



ship or privileges based on economic factors that are unrelated to quality of care or competency considerations;" and

WHEREAS, economic credentialing may take many forms, including but not limited to:

1. The hospital uses exclusive contracts for all services (surgery, internal medicine, OB-GYN, etc) thereby bypassing the medical staff peer review process under the guise of "improved hospital efficiency;"
2. The hospital uses computer-collected economic performance criteria in the appointment and reappointment process, not at the medical staff level, but at the board level;
3. The hospital closes a medical staff department or division ostensibly for quality reasons, but, in reality, for the purpose of the hospital's bottom line; and

WHEREAS, the American Medical Association supports the following policy concerning hospital clinical privileges:

1. Clinical privileges are defined as the right of a medical staff member to provide specific patient care services in a manner consistent with licensure, education, and expertise;
2. Privileges are conferred by the hospital governing body upon recommendation of the medical staff and shall include access to those hospital resources essential to the full exercise of such privileges;
3. The hospital governing body may abridge one's privileges only upon recommendation of the medical staff, for reasons related to professional competence, adherence to appropriate standards of medical care, health status, or other parameters agreed upon by the medical staff. Procedures described in the medical staff bylaws must be followed; and

WHEREAS, AMA opposes the use of economic criteria not related to quality to determine an individual physician's qualifications for the granting or renewal of medical staff membership or privileges; now therefore be it

RESOLVED, that the KMA evaluate other state statutes that allow *only* physicians the right to credential physicians; and be it further

RESOLVED, that the KMA alert its membership to economic credentialing and its effect on the limitation of physician practice rights; and be it further

RESOLVED, that KMA adopt the position of AMA, as set forth above, opposing economic credentialing.

## Recommendations, Reference Committee 2:

Reference Committee No. 2 considered Resolution C, Economic Credentialing: Stop It Now, introduced by McCracken County Medical Society, and Resolution DD, Economic Credentialing, introduced by the Board of Trustees, together because of their related subject matter.

Reference Committee No. 2 recommends the adoption of Resolution DD in lieu of Resolution C.

## Resolution D

### Kentucky Model Medical Staff Bylaws McCracken County Medical Society

WHEREAS, many state medical associations now offer Model State Medical Staff Bylaws tailored to their state and conforming to federal and individual state health care statutes; and

WHEREAS, the KMA in its leadership position should offer to its members Kentucky Model Medical Staff Bylaws and a recommended legal firm in this Commonwealth to review individual bylaws; and

WHEREAS, Kentucky medical staffs would be willing to compensate the KMA for this necessary KMA service; now therefore be it

RESOLVED, that the KMA develop Kentucky Model Medical Staff Bylaws and evaluate and recommend legal firms that are willing to review on behalf of the Kentucky medical staffs newly written or amended Medical Staff Bylaws.

## Resolution CC

### Kentucky Model Medical Staff Bylaws Board of Trustees

WHEREAS, many state medical associations now offer model state medical staff bylaws tailored to their state and conforming to federal and individual state health care statutes; and

WHEREAS, KMA has compiled a collection of various medical staff bylaws and guidelines from those states where they are available and has made that information available to KMA members through their association with the KMA Hospital Medical Staff Section; and

WHEREAS, the Kentucky Medical Association, in its leadership position, should offer to its members model medical staff bylaws and/or guidelines for the drafting of medical staff bylaws; and

WHEREAS, the cost of providing model bylaws or suggested guidelines must be passed through to hospital medical staffs which request such services; now therefore be it

RESOLVED, that the Kentucky Medical Association develop model medical staff bylaws and/or guidelines suitable for Kentucky and make them available to hospital medical staffs, upon request, for an appropriate fee.

FISCAL NOTE: \$500-\$1500

## Recommendations, Reference Committee 2:

Reference Committee No. 2 next considered Resolution D, Kentucky Model Medical Staff Bylaws, introduced by McCracken County Medical Society, and Resolution CC, Kentucky Model Medical Staff Bylaws, introduced by the Board of Trustees, together because of their related subject matter.

It was pointed out that the Fiscal Note indicated the cost to KMA for developing guidelines would be \$500-\$1500, and for model bylaws would be \$10,000-\$15,000. It was further noted that Resolution CC calls for the development of model bylaws "and/or" guidelines. Appropriate language could then be developed specifically by the individual hospital.

Reference Committee No. 2 recommends that Resolution CC be adopted in lieu of Resolution D.

## **Resolution E**

### **Access to Tobacco by Children Pulaski County Medical Society**

WHEREAS, the Kentucky Medical Association House of Delegates has urged the Kentucky General Assembly to prohibit the use of tobacco and tobacco products on public school property; and

WHEREAS, the KMA opposes the sale and distribution of tobacco and tobacco products to individuals under the age of 18; and

WHEREAS, the KMA encourages the Kentucky General Assembly to increase cigarette taxes in order to lower the number of new teenage smokers; and

WHEREAS, the KMA House of Delegates has expressed its disapproval of the practice of advertisements of tobacco products, particularly those that glamorize the usage of tobacco products; now therefore be it

RESOLVED, that KMA endorses and supports legislative proposals which accomplish House of Delegates policies on tobacco; and be it further

RESOLVED, that KMA opposes the use of billboards or other mediums which advertise tobacco products visible from school property (K-12); and be it further

RESOLVED, that tobacco vending machine usage be restricted to persons over 18 years of age; and be it further

RESOLVED, that in those areas where free smoking cessation clinics are unavailable that local health departments make available free smoking cessation clinics to children under the age of 18.

## **Resolution K**

### **Eliminating Access to Tobacco by Children Fayette County Medical Society**

WHEREAS, cigarette smoking is the greatest single cause of preventable death in the United States, according to the Surgeon General; and

WHEREAS, Kentucky leads the nation in both the prevalence of cigarette smoking and smoking-attributable mortality, according to the Centers for Disease Control; and

WHEREAS, the Kentucky Medical Association has endorsed the concept of eliminating access to tobacco by children; and

WHEREAS, the Kentucky Medical Association has agreed to work with the Tobacco-Free Young Kentuckians to accomplish this goal; now therefore be it

RESOLVED, that the Kentucky Medical Association use every means at its disposal to support BR 328 (an Act relating to public health), summarized as follows:

#### **SECTION 1:**

There shall be no distribution of free tobacco products at a public assembly where children aged 18 or under can reasonably be expected to be present.

#### **SECTION 2:**

No person shall sell any tobacco products to any person under the age of 18.

#### **SECTION 3:**

No person, except adult employees of the school system who smoke in a designated room for that person, shall smoke on school property during school hours. Outside sporting events are excluded.

#### **SECTION 4:**

An assessment of the number of students using tobacco products and the effectiveness of an individual school's efforts to encourage students to stop smoking shall be a component of monitoring student performance as mandated by the Kentucky Education Reform Act of 1990.

#### **SECTION 5:**

No billboards or other advertising devices which advertise tobacco products shall be visible from school property.

#### **SECTION 6:**

All vending machines that are not monitored by a person over the age of 18 or that are located in a place where children under the age of 18 may legally enter must be fitted with a special token to be purchased from a person over the age of 18.

#### **SECTION 7:**

All health departments must make available without charge to children under the age of 18 stop-smoking clinics, or must refer to a local agency that is a provider of this service. Also, they shall notify all schools in the county of the availability of such programs, and the school shall make this information available to students.

### **Recommendations, Reference Committee 2:**

Reference Committee No. 2 considered Resolution E, Access to Tobacco by Children, introduced by Pulaski County Medical Society, and Resolution K, Eliminating Access to Tobacco by Children, introduced by Fayette County Medical Society, together due to their similar subject matter.

The Committee heard a great deal of discussion in support of Resolution E and Resolution K and felt that their intent would best be served by combining elements of the two Resolutions. Reference Committee No. 2 recommends that Resolution E be amended by inserting material from



Resolution K in place of the first "Resolved" of Resolution E. The "Resolved" of Resolution E, with deletion and addition, would then read as follows:

**RESOLVED, that the Kentucky Medical Association use every means at its disposal to support legislation that would contain the following elements:**

1. **RESOLVED, that KMA oppose opposition to the use of billboards or other mediums which advertise tobacco products visible from school property (K-12); and be it further**
2. **RESOLVED, that tobacco vending machine usage be restricted to persons over 18 years of age; and be it further**
3. **RESOLVED, that in those areas where free smoking cessation clinics are unavailable, that local health departments make available free smoking cessation clinics to children under the age of 18; and**
4. **no person, except adult employees of the school system who smoke in a designated room for that purpose, shall smoke on school property during school hours; outside sporting events are excluded.**

Reference Committee No. 2 recommends adoption of Resolution E, as amended, in lieu of Resolution K.

## **Resolution E, adopted in its final form, reads as follows:**

WHEREAS, the Kentucky Medical Association House of Delegates has urged the Kentucky General Assembly to prohibit the use of tobacco and tobacco products on public school property; and

WHEREAS, the KMA opposes the sale and distribution of tobacco and tobacco products to individuals under the age of 18; and

WHEREAS, the KMA encourages the Kentucky General Assembly to increase cigarette taxes in order to lower the number of new teenage smokers; and

WHEREAS, the KMA House of Delegates has expressed its disapproval of the practice of advertisements of tobacco products, particularly those that glamorize the usage of tobacco products; now therefore be it

**RESOLVED, that the Kentucky Medical Association use every means at its disposal to support legislation that would contain the following elements:**

1. Opposition to the use of billboards or other mediums which advertise tobacco products visible from school property (K-12);
2. Tobacco vending machine usage be restricted to persons over 18 years of age;
3. In those areas where free smoking cessation clinics are unavailable, local health departments make available free smoking cessation clinics to children under the age of 18; and
4. No person, except adult employees of the school system

who smoke in a designated room for that purpose, shall smoke on school property during school hours; outside sporting events are excluded.

## **Resolution FF**

### **Radon Exposure Board of Trustees**

WHEREAS, exposure to radon poses a serious threat to the health of the citizens of Kentucky; and

WHEREAS, the Environmental Protection Agency has identified radon as the second leading cause of lung cancer and the leading cause among nonsmokers; and

WHEREAS, high levels of radon in homes, businesses, and schools can be reduced successfully and economically with appropriate treatment; now therefore be it

**RESOLVED, that the KMA support radon awareness activities of the state radon program operated through the Radiation Cabinet Branch of the State Health Department; and be it further**

**RESOLVED, that citizens of the Commonwealth be urged to conduct radon screening in their homes, schools, work places, and other public places; and be it further**

**RESOLVED, that the KMA work with the State Health Department in disseminating radon physician guides and other appropriate information to members in order that patients may be educated to the danger of excessive radon exposure.**

Reference Committee No. 2 next considered Resolution FF, Radon Exposure, introduced by the Board of Trustees. The Committee would like to point out that the Environmental Protection Agency is only one source for information on the relative hazards of radon exposure, and the health department could not support the statement made in the second "Whereas" of the Resolution.

The Reference Committee felt it was important to emphasize other health hazards and the need for standardized measuring and reporting, and would therefore recommend that the last "Resolved" be amended and an additional "Resolved" be added, as follows:

**RESOLVED, that the KMA work with the State Health Department in disseminating radon physician guides for physicians and other appropriate information on this and other health hazards to members in order that patients may be educated to the danger of excessive radon exposure, and be it further**

**RESOLVED, that KMA work with the State Health Department to promote standardized measuring and reporting of radon levels.**

Reference Committee No. 2 recommends the adoption of Resolution FF as amended.

**Resolution FF, adopted as amended, reads as follows:**

WHEREAS, exposure to radon poses a serious threat to the health of the citizens of Kentucky; and

WHEREAS, The Environmental Protection Agency has identified radon as the second leading cause of lung cancer and the leading cause among nonsmokers; and

WHEREAS, high levels of radon in homes, businesses, and schools can be reduced successfully and economically with appropriate treatment; now therefore be it

RESOLVED, that the KMA support radon awareness activities of the state radon program operated through the Radiation Cabinet Branch of the State Health Department; and be it further

RESOLVED, that citizens of the Commonwealth be urged to conduct radon screening in their homes, schools, work places, and other public places; and be it further

RESOLVED, that the KMA work with the State Health Department in disseminating radon guides for physicians and other appropriate information on this and other health hazards to members in order that patients may be educated to the danger of excessive radon exposure; and be it further

RESOLVED, that KMA work with the State Health Department to promote standardized measuring and reporting of radon levels.

**Recommendations, Reference Committee 2:**

Mr Speaker, Reference Committee No. 2 recommends the adoption of the report of Reference Committee No. 2 as a whole.

Mr Speaker, I want to personally thank the members of the Reference Committee for their work. Members of the Committee are James T. Engle, Jr, MD, Elizabethtown; Samuel G. Eubanks, Jr, MD, Louisville; R. Gary Marquardt, MD, Murray; and Susan H. Prasher, MD, Ashland. I also want to personally thank Sharon Heckel for her assistance in the preparation of this report.

**Respectfully submitted,  
REFERENCE COMMITTEE NO. 2**

**Harry W. Carter, MD, Ft. Mitchell, Chairman  
James T. Engle, Jr, MD, Elizabethtown  
Samuel G. Eubanks, Jr, MD, Louisville  
R. Gary Marquardt, MD, Murray  
Susan H. Prasher, MD, Ashland**

*Editorial Note: Unless otherwise noted, the Reference Committee action on each Report and Resolution was accepted as printed. Any opposing action taken is stated in discussion following the item.*

**REPORT OF REFERENCE COMMITTEE NO. 3**

**Scott B. Scutchfield, MD, Danville, Chairman**

- 20. Report of the Maternal Mortality Study Committee
- 21. Report of the Committee on National Legislative Activities
- 22. Report of the Committee on State Legislative Activities
- 23. Report of the Committee on Professional Liability Insurance
- 24. Report of the Committee on Impaired Physicians
- 25. Report of the Committee on Care for the Elderly
- Resolution G — Definition of Surgery  
(Warren County Medical Society)
- Resolution H — 1990 Medicare Fee Discrimination Against New Physicians  
(KMA Young Physicians Steering Committee)
- Resolution L — Fair Treatment of Physicians by the Federal Government  
(Jefferson County Medical Society)
- Resolution M — Do Not Resuscitate Orders in the Pre-Hospital Setting  
(Jefferson County Medical Society)
- Resolution V — Publication of Rape Victims' Names  
(KMA Resident Physicians Section)
- Resolution X — "Gag Rule" on Pregnancy Option Counseling  
(Jefferson County Medical Society)

**ITEMS FOR CONSENT**

Reference Committee No. 3 reviewed the following items and recommends they be filed or adopted, as indicated, by consent of the House, without discussion:

- 20. Report of the Maternal Mortality Study Committee — filed
  - 23. Report of the Committee on Professional Liability Insurance — filed
  - 25. Report of the Committee on Care for the Elderly — filed
- Mr Speaker, Reference Committee No. 3 recommends adoption of the Consent Calendar as a whole.

**Report of the Maternal Mortality Study Committee**

With the continued decline in the number of maternal deaths, the Maternal Mortality Study Committee met only once this year, in conjunction with the Annual Meeting of the Kentucky Medical Association. This arrangement affords the members the opportunity of the best use of their time. Kentucky is cooperating with the Center for Disease Control in collaboration with the Maternal Mortality Special Interest Group of the American College of Obstetricians and Gynecologists. The maternal deaths in the United States from 1979-1986 were reported in Vol. 76, No. 6, December 1990, *Obstet-*



rics and Gynecology.

Below is a summary of an interesting case.

A 38-year-old Korean (gr 5, para 1, ab 3) delivered vaginally a 5 lb male in 1978. She delivered spontaneously a 7 lb, 5 oz, male on 9-5-85 and had severe vaginal bleeding following the delivery of the placenta. Intravenous methergine, uterine massage, IV oxytocin, and curettage with a very large, sharp curet were to no avail. She was transfused with 18 1/2 units of blood, normal saline, and an emergency hysterectomy was performed. On opening the abdomen, a large, right broad ligament hematoma was discovered from a perforation along the right lateral aspect of the lower uterine segment. She died three hours following delivery. At autopsy, a lateral laceration of the uterine cervix at 9 o'clock was found, with extension of this several centimeters into the lower uterus and one-half of the right lateral uterine wall.

The Committee considered this a direct obstetric death with possible preventable factors.

Rupture of the uterus is something that must be considered in these times and dealt with promptly.

**John W. Greene, MD**  
**Chairman**

## Report of Committee on Professional Liability Insurance

The Committee on Professional Liability Insurance met on one formal occasion during the 1990-91 Associational year. Due to the fact that Wally O. Montgomery, MD, was on active military duty in the Persian Gulf, your President served as Acting Chairman. The Committee met to discuss a proposal that the Kentucky Hospital Association and KMA jointly contract with the Gallup Organization, Inc, of Princeton, New Jersey, to conduct a public opinion research study. The overall purpose is to profile key legislators, business executives, and the general public to determine the public's attitudes and opinions regarding various health care issues.

The two-phased study proposed will provide an assessment of consumer and "opinion leader" attitudes and opinions concerning current health policy issues and perceptions of future concerns regarding health care. The stated objectives of the study include, but are not restricted to, the following issues related to medical and health care providers:

To assess consumer and opinion leaders' attitudes on a variety of social and policy issues related to the provision of health care services; consumer acceptance of increased taxes to cover health care costs of the uninsured and indigent; consumer and opinion leaders' attitudes on various forms of health care cost coverage of the uninsured; degree of acceptance among both groups of a form of a "National Health Care System" similar to Canada's or Great Britain's; consumer and opinion leaders attitudes toward the cost of health care;

beliefs about the ways in which hospitals and medical practices operate; measure the public's and opinion leaders' awareness of and attitudes toward medical and hospital malpractice damage awards in lawsuits; measure the public's and opinion leaders' awareness on caps or limitations imposed on judges or juries in the award of actual and punitive damage awards.

This outline only briefly touches on the numerous topics in the poll.

To accomplish the consumer objectives, Gallup will utilize a telephone survey of a statewide random sample of the general public. In addition, members of the Kentucky General Assembly will be interviewed and polled on a variety of topics relating to health care. Finally, a poll will also be conducted with a random sample of Kentucky business persons to ascertain their views of the health care delivery system.

We learned in KMA's 1987-88 Tort Reform Campaign that a survey of public opinion is crucial to the success of a public or legislative campaign. The poll will be completed prior to the convening of the 1992 Kentucky General Assembly and results will be printed in the *Journal of the KMA* for members' information.

Our long-term objectives in the tort reform campaign remain the same:

Primary recommendations:

1. Constitutional amendment to permit the Kentucky General Assembly to cap noneconomic awards;
2. A No-Fault Approach to Medical Malpractice/A Patient Compensation Plan.

Secondary recommendations:

1. Reduce Statute of Limitations for minors;
2. Mandate periodic payments of future damages in lieu of lump sum payments;
3. Adopt a Perinatal Neurological Impairment Compensation Program.

In October 1990, the Kentucky Supreme Court held unconstitutional the medical malpractice statute of limitations which had barred the filing of lawsuits more than five years after any alleged negligence took place. That was not a total shock since the 1985 Court had ruled unconstitutional a similar statute relating to architects and engineers. In 1989, the same Court decided that Kentucky's Confidentiality of Peer Review statutes could not pass constitutional muster. More than a decade ago, the Court found a substantial portion of the 1976 KMA tort reform package unconstitutional. Unfortunately, with recent changes in the makeup of our state Supreme Court, we are witnessing a swing to the left that is plaintiff-oriented and may mean bad news to physicians.

During the 1992 Session, we plan to continue the weekly "Legislative Bulletin." In addition, a Legislative Handbook will be mailed to every member prior to the Session and a wrap-up of KMA activities will be completed and mailed

following the Session.

We thank the members for their strong support of the legislative effort, particularly their assistance and patience as we continue to wage a campaign to address tort reform.

**Preston P. Nunnelley, MD**  
**Acting Chairman**

## **Report of Committee on Care for the Elderly**

The Committee on Care for the Elderly enjoyed a productive year. Last year the Committee was instrumental in the formation of the Kentucky Geriatrics Society, which was recognized by the Board of Trustees and now stands as an acknowledged subspecialty group of the Kentucky Medical Association. The KGS held its first annual meeting during the KMA Annual Meeting, and had as its speaker the President of the American Geriatrics Society. Subsequently, the Society held a CME program in March, and plans are underway for additional meetings, including a program during the KMA meeting this fall.

This year efforts were undertaken to determine interest in a Kentucky Medical Directors Association. Nationally, such an association exists and is constituted for the benefit of physician directors of nursing homes. This group has not been active in the state for a number of years. With the growing emphasis on care of the elderly and associated nursing home problems, it was the Committee's opinion that this area should be explored, and efforts in this regard continue.

Previously, the Committee had developed an adult abuse brochure together with the Cabinet for Human Resources. This brochure continues to be used widely by several state agencies, including the Office of the Attorney General, and has been an effective tool in training sessions for ancillary personnel who work with the elderly. Copies of this brochure are available on request from the KMA office.

As part of its ongoing education mission, the Committee continued to solicit articles for the *Journal* on issues relating to the elderly, and it is felt that these would serve as helpful vehicles for the practitioner in remaining current on new developments. Some difficulties have been experienced with the publication of these articles in the *Journal*, but it is hoped that closer cooperation with the *Journal* editors will see a renewal of the articles' appearance.

For the past two years the Committee has initiated what it has called an elderly Steering Committee, which is composed of representatives of the American Association of Retired Persons, the Kentucky Association for Older Persons, and the Special Advisory Committee on Aging to the Legislative Research Commission. Each year the Committee has sponsored a forum which has consisted of a seminar on areas of mutual interest to all groups. The purpose of these seminars, in addition to educational content, is to maintain

rapport among the principal groups noted, and it is felt that some very effective communications have been established.

This year, the forum topic was "Driving Impairment in the Aging." Faculty members for the forum were Arthur H. Keeney, MD; State Representative Anne Meagher Northup, who is a member of the House Transportation Committee; and Mr David Salyers, Director of the Highway Safety Program for the Kentucky State Police. The forum was most informative for all the groups. From the physician standpoint, it was learned that through the State Police, physicians can assist families who have elderly drivers in obtaining restricted drivers' licenses. These licenses can include such measures as time-of-day restrictions and restrictions on distance from home. In addition, a medical Advisory Board to the State Department of Transportation can help in other evaluation efforts to assure that competent elderly drivers can maintain this privilege, while impaired drivers can be restricted in a sensitive but reasonable manner which recognizes their freedom, but also their obligation to safety concerns. Further details from this perspective will be made available, hopefully, in an article to appear in the *KMA Journal*.

The Committee is undertaking further efforts to try to disseminate information on this issue through the media and to act as liaison with organizations representing the elderly.

Through its efforts, the Committee feels it is making some progress in helping to coordinate educational opportunities in the area of geriatric care, as well as serving as a focal point for communications among all affected groups. This can only help to serve our common interests, while maintaining the advocacy position that physicians fill for the elderly. Likewise, these efforts, it is hoped, are establishing advocacy for physicians with these groups in the public arena.

**John C. Wright, II, MD**  
**Chairman**

## **END OF CONSENT CALENDAR ITEMS**

### **Report of Committee on National Legislative Activities**

Medicare physician payment reform has unquestionably consumed the greatest attention by the federation of medicine and Congress, particularly in recent months, and the Committee on National Legislative Activities has directed considerable activity to this issue.

In June the Health Care Financing Administration (HCFA) published notice of proposed rules to implement Medicare payment reform, with the final rules scheduled for publication in late October. Transition to the new system is to begin starting January 1, 1992.

Medicare payment reform centers around the Resource-Based Relative Value Scale (RBRVS) in which AMA and other components of the federation have played a major role in



an attempt to assure appropriate medical input and payment equity among specialists.

The overwhelming concern with these regulations has been the development by HCFA of a conversion factor so that payments under the new system will remain the same as if the current system had continued. To accomplish this intent, HCFA arbitrarily made changes to the conversion factor which are contrary to congressional intent. The first approach of the conversion factor was what HCFA termed a "behavioral" offset. This is an assumption that physicians will automatically increase the volume of services as payment is increased for given procedures.

A second aspect of the conversion factor which is objectionable relates to the original congressional intent to increase payment to rural primary care physicians while reducing other so-called "over-priced" procedures. While the federation agreed in principle with this theory, HCFA's conversion factor component would change this formulaic correction to the point where higher priced procedures would be radically reduced immediately, and rural primary care payments would be increased slightly, if at all.

The third component would result in tripling the amount of the proposed reduction in payments over the congressional mandate called for in OBRA '89. In the first week of June, KMA held its annual Washington visitation and dinner and was fortunate, because of advanced information received from AMA, to be able to voice concerns to Kentucky's Congressmen about the conversion factor issue. Subsequently, the AMA has undertaken to amend provisions of OBRA '89 which would allow this conversion factor variation generated by HCFA to occur.

As part of this effort, KMA has been in contact with all of its Congressmen and has received some significant support for the amendment. In the meantime, comments in opposition to the proposed rules are being developed and will be submitted as part of the routine rule-making process. During this period, KMA has also called on all members to contact their Congressmen seeking support for the OBRA amendment. This conversion factor imposition by HCFA is felt to be arbitrary, demeaning to physicians, and contrary to congressional intent.

During the beginning of the Associational year and at the time of the last Budget Reconciliation Act, KMA lent its support to national federation efforts to support HR 4475, the "Medicare Physician Relief Amendments of 1990." This bill was successful and some provisions included were to: allow physicians to continue medical coverage of patients of colleagues without billing separately, allow professional associations to appeal denied claims on behalf of a class of physicians, and prohibit carriers from charging physicians for information necessary to comply with Medicare laws and regulations. Again, a good deal of support from Kentucky's congressional delegation was instrumental in passage of this bill.

Another piece of legislation of interest to medicine was S 489, introduced by Senator Orrin Hatch of Utah, entitled "Insuring Access Through Medical Liability Reform." Some provisions of this bill were: limits on noneconomic damages, periodic payments for future damages, and recognition of collateral sources. Owing to restrictions to Kentucky's Constitution, this national legislation would not alleviate Kentucky's situation, but congressional attention on the issue to any degree was felt to be helpful.

Considerable effort was spent this year also in effecting implementation of the Clinical Laboratory Improvement Act of 1988. This bill would classify all laboratories, including physician office labs, and require federal monitoring. Originally proposed regulations were withdrawn because of overwhelming protests by organized medicine. In revised form, the regulations would lessen requirements for physician office labs, but would still require payment of a waiver fee, which is tantamount to an annual registration. As of the time of this writing, the waiver fee issue has yet to be resolved.

In another Medicare development, it was learned that HCFA had developed a plan to conduct demonstration projects on competitive bidding for specific surgical procedures. The obvious thrust of this measure was cost reduction. Because of the negative precedent involved and the obvious effects on quality and access to care, KMA continued its congressional contacts to try to forestall this measure. This was done in conjunction with the Kentucky Academy of Eye Physicians and Surgeons, and support for this restriction was garnered from the US House of Representatives Committee on Ways and Means. It is hoped that this issue is at least temporarily restrained.

In a related Medicare situation, the Office of Management and Budget (OMB) had initially directed carriers to delay claims payment to physicians because of increased Medicare requirements and the administrative costs of claims processing. Through the efforts of the medical federation, including contacts with Kentucky's congressional delegation, this claims payment delay was resolved and contingency funds were released by the OMB so that claims would be paid on time. Concern still remains that carriers intend to give precedence to claims payment for electronically submitted claims. This is obviously inequitable to individuals and small groups of physicians treating Medicare patients.

As indicated earlier, a Washington visitation was conducted during the early part of June, and helpful and positive contacts were made. Approximately 20 physicians and their spouses were in attendance, and every congressional office was visited. The subsequent banquet was not well attended by the Congressmen, owing to a late vote, but positive communications were continued, and were particularly beneficial in light of the RBRVS conversion factor issue.

There is little doubt that payment reform implementation will be the focus of attention for the house of medicine in this session of Congress. Some have predicted that with



the advent of RBRVS, many Medicare problems would be resolved, but experience indicates that HCFA will continue to attempt to reduce costs for Medicare beyond congressional intent. This mandates continued vigilance by your Committee, your Association, and all members. We are particularly appreciative of the efforts of those members who have contacted their Congressmen directly, and feel that this is the most effective method of communicating our concerns on critical issues.

The Committee welcomes input by any members and any assistance on legislative matters that affect the profession.

**Donald C. Barton, MD**  
**Chairman**

**Recommendations, Reference Committee 3:**

Reference Committee No. 3 reviewed the Report of the Committee on National Legislative Activities. The Reference Committee compliments the Committee on National Legislative Activities for its time in visiting Washington and its success in obtaining legislative intervention to block HCFA's decision to go against the budget neutrality position and recommends that KMA continue to apply pressure to enact legislation to ensure budget neutrality.

Reference Committee No. 3 recommends this report be adopted.

**Report of Committee on State Legislative Activities**

In January 1991 the Kentucky General Assembly (KGA) convened for its regular reorganizational session. Following the reorganization, the Governor called a special session. At the outset of the special session the Governor placed two items on the agenda of specific concern to medicine. Our primary concern was Senate Bill 2, the solid waste disposal bill. There were several attempts to bring hospital incinerators and office pick-up of medical waste under its provisions. The Kentucky Hospital Association and Kentucky Medical Association opposed these measures, pointing out that hospital incinerators fall under air quality measures and regulations and that medical waste should be dealt with during the regular session under different provisions.

The Governor also included drunk driving in the ongoing call and House Bill 11 was adopted which:

- Allows first-time offenders who are convicted to apply for a hardship or occupational drivers license for the last 60 days of a 90-day suspension. The license is to be valid only for travel to and from work, school, or medical care.
- Makes driving with a blood alcohol content exceeding 0.10 illegal per se. Under current law drivers with that level of impairment are only assumed to be drunk.

- Allows district court judges to suspend the license of those who refuse to take a blood alcohol test, those drivers who are between the ages of 16 and 21, and those who have had a previous DUI conviction in the last five years.
- Makes fourth and subsequent offenses in a five-year period a felony, punishable by one to five years in prison and a \$10,000 fine. Minimum jail time of 120 days is also required.
- Prohibits prosecutors from reducing DUI charges to lesser offenses when the blood alcohol content is .10 or higher or when there has been a refusal to submit to a blood test.

We are pleased to see the KGA strengthen the DUI laws and will continue supporting measures to get drunk drivers off the road.

In a surprise move, the Governor added Medicaid to the special call noting the crisis created by new federal mandates. On February 22, 1991, the Kentucky General Assembly adopted House Bill 21. HB 21 is a broad grant of authority to the Cabinet for Human Resources (CHR) Department of Medicaid Services to assess certain health care providers a percentage of their Medicaid reimbursements. HB 21 was enacted as a short-term cure for the current Medicaid budget deficiencies caused by increased federal mandates. In order to balance the Medicaid budget, the state is seeking federal matching funds which are currently paid at a ratio of three federal dollars to one state dollar. The state intends to use the health care providers' assessments to match with federal funds pursuant to the above formula. The state will apply 50% of the total state and federal funds to cure the current Medicaid deficit and to provide surplus funds for future federal mandates. The remaining 50% of the providers' assessments and federal matching funds will be reimbursed to the provider in a manner to be set forth in the regulations.

There have been several questions regarding the amount of the reimbursement and the 200% guaranteed return to physicians set forth in HB 21. HB 21 provides that individual physicians are guaranteed a minimum of a full refund and physicians as a group will be guaranteed a 200% return on the total amount of all physicians' assessments. Therefore, if physicians are assessed \$17.5 million per year, the state will reimburse Kentucky physicians \$35 million. However, CHR has the discretion to distribute those funds remaining after each individual physician is provided a dollar-for-dollar return in a manner it deems most equitable. Therefore, although each physician is guaranteed a return of his or her individual assessment through increased reimbursement, the 200% return guaranteed by HB 21 may be distributed to certain classes of physicians in a manner which will cure deficiencies in the reimbursement system developed over the years and hopefully make the Medicaid reimbursement system more equitable for all. CHR will be the ultimate decision maker on this issue. CHR has advised that it will communicate its intentions on this reimbursement issue with KMA as they develop.

CHR is in the process of determining how to institute



the 15% assessment directed by HB 21 as adopted by the 1991 special session. The Cabinet is working with KMA to determine the maximum assessment, which hopefully can be accomplished by July 1, 1991. CHR staff noted that the collection and accounting procedures will take some time. The current plan calls for physicians being billed at the end of the first quarter for up to 15% of Medicaid reimbursement received during that quarter. The physician will then submit payment, and each quarter the physician will be reassessed. The KenPAC fee is not expected to be changed.

As pointed out to the KMA membership, the Administration had three options to resolve the Medicaid budget crisis:

1. Severe reductions in reimbursement for Medicaid services;
2. Raise taxes \$80 million;
3. Incorporate options permitted under OBRA 1990 (as adopted in HB 21).

Essentially, the third option was the only option.

The following criteria were utilized by KMA's Executive Committee in making a decision whether or not to support the program:

1. Assure continuing access for Medicaid patients to physicians.
2. Assure those physicians whose practices depend upon the Medicaid program and treat a predominant number of Medicaid recipients that the program is equitable and fair.
3. Assure each individual physician the opportunity to choose whether to participate or not to participate.

Of the three legislative options, the OBRA provisions presented the least reduction in reimbursement for services of Kentucky physicians.

The following actions from the 1990 House of Delegates were referred to COSLA for action:

- a. **Recommendation that KMA oppose all mandated health insurance benefits.** (From 1990 COSLA Final Report) The legislative committee has traditionally opposed all mandated benefits. This recommendation establishes official support from the House of Delegates to continue existing policy.
- b. **Resolution O directs the study of the establishment of a centralized data base for all prescribed drugs or medication in Kentucky for easy access by physicians and pharmacists in the Commonwealth.** While most physicians and pharmacists have computers in their offices, it is doubtful that programs could be developed to make them compatible to a centralized state agency station. In addition, all prescription information on an individual and a provider would be readily available to all pharmacy clerks and physician office assistants. Privacy and confidentiality would be impossible to monitor. The Committee recommends that Resolution O is not feasible due to costs and has potential to violate physician/patient relationships.

c. **Resolution D — Certificate of Need** — reaffirms existing policy of KMA but places much more emphasis upon KMA's lobbying activity by supporting the repeal of exemptions granted to Jefferson County hospitals. Resolution D resolved that KMA endorse the retention of CON, exempt physicians offices from CON, and oppose exemption from CON by geographical area.

d. **Resolution G and Resolution P recommend continuing support of mandated seat belt legislation and reaffirm KMA's existing legislative policy.**

e. **Resolution Q recommends a legislative study on water jet skis, boat safety, etc.** KMA will seek a legislative sponsor in 1992 to introduce this Study Resolution.

f. **Resolution W directs that legislation be drafted to standardize Medicare supplement policies.** New federal provisions directed the National Association of Insurance Commissioners (NAIC) to design up to 10 "approved" Medicare supplement policies. NAIC has now completed and forwarded these to Congress. KMA will seek some assurance from the state Insurance Commissioner that the recommendations are adopted either through regulation or legislation. The Committee will closely monitor this situation.

g. **Resolution H called for the popular election of the State Commissioner of Insurance rather than gubernatorial appointment.** Although this Resolution was not adopted by the 1990 House of Delegates, the Board of Trustees asked the Committee to review the matter. After considerable discussion, the Committee recommends that KMA not support the concept of an "elected Insurance Commissioner." This change would require a constitutional amendment and would create roadblocks in KMA's effort to seek alterations in Section 54 of the Constitution to alleviate the liability crisis.

Representative Susan Stokes addressed the Committee regarding proposed legislation to establish a statewide health data bank for use by consumers to compare price and quality of frequently used health care services. The proposal requires health care providers to submit various data to the state in addition to the present information forwarded to insurance companies. Comparative information would then be published or available to consumers to provide guidelines upon which health care decisions could be made as to the choice of physician/hospital, etc. The Commission would be created within two months following the effective date of the legislation and consist of 19 members.

Representative Stokes responded to questions and explained that Pennsylvania has the most advanced Commission of the 17 states now under this legislation. Regarding the privacy of patients whose data is submitted to this data bank, LRC staff replied that patients would be identified by code and the Commission would make all decisions on release of information, noting that information in the data bank might be helpful to physicians. Committee members pointed



out that similar information is already available through private and government carriers and other sources. Many questions were posed in an effort to understand the ultimate goal of this legislation. The Committee, while perceiving the intent of Health Data Commission legislation as consumer-oriented, notes that it is difficult to address quality of care in a meaningful way.

The Committee heard a presentation concerning problems incurred as a result of physical therapists revising or countermanding physicians' orders and treating patients without physician referral. KMA staff was directed to study ways to reverse present legislation/regulations by which physical therapists independently diagnose and treat patients. Following a study, if appropriate, a Resolution will be drafted for the 1991 House of Delegates meeting.

The Committee reviewed correspondence received from Kosair-Children's Hospital staff requesting KMA's support for a legislative ban on fireworks except for professional displays. The Committee recommends that KMA support legislation to ban all fireworks with the exception of approved professional displays.

The 1992 Session will be very difficult for KMA. Numerous nonphysician practitioners will seek expanded roles in the delivery of medical care, including direct reimbursement. The cost of health care, especially the extreme reactions by our business allies, and restricted access to physicians in rural and inner city areas provide a catalyst for change in how and by whom health care will be delivered in the future. Workers' Compensation rates for medical care are rising at an unacceptable rate and this issue could be a major focus in 1992.

A special appeal has gone out to members to assist as Key Contacts during the 1992 Kentucky General Assembly. We are extremely concerned with the potential this explosive situation has for physicians and patients.

During the major part of the Associational year I have filled in as Chairman of COSLA. On behalf of the Committee and all physicians, allow me to personally express thanks for members' willingness to get involved in the legislative process and take stands which are sometimes difficult but always in the long-term interest of patients and the profession.

My special regards go to Wally O. Montgomery, MD, and each and every other Kentucky physician and their families for their service in the Persian Gulf. Special accolades go to those physicians and support personnel who performed so admirably and unselfishly during the crisis.

**Preston P. Nunnelley, MD**  
**Acting Chairman**

**RECOMMENDATIONS**

1. The Committee on State Legislative Activities recommends that 1990 Resolution O is not feasible due to costs

and has potential to violate physician/patient relationships.

2. The Committee on State Legislative Activities recommends that KMA not support the concept of an "elected Insurance Commissioner." This change would require a constitutional amendment and would create roadblocks in KMA's effort to seek alterations in Section 54 of the Constitution to alleviate the liability crisis.
3. The Committee on State Legislative Activities recommends that KMA support legislation to ban all fireworks with the exception of approved professional displays.

**Recommendations, Reference Committee 3:**

Reference Committee No. 3 reviewed the Report of the Committee on State Legislative Activities and its three recommendations which read as follows:

1. The Committee on State Legislative Activities recommends that 1990 Resolution O is not feasible due to costs and has potential to violate physician/patient relationships.
2. The Committee on State Legislative Activities recommends that KMA not support the concept of an "elected Insurance Commissioner." This change would require a constitutional amendment and would create roadblocks in KMA's effort to seek alterations in Section 54 of the Constitution to alleviate the liability crisis.
3. The Committee on State Legislative Activities recommends that KMA support legislation to ban all fireworks with the exception of approved professional displays.

Reference Committee No. 3 extends its thanks to Preston P. Nunnelley, MD, for chairing the Committee on State Legislative Activities and the Committee on Professional Liability Insurance during the absence of Wally O. Montgomery, MD, who served in Operation Desert Storm. It is noted that Doctor Nunnelley chaired these two Committees in addition to his responsibilities as President of KMA.

Reference Committee No. 3 recommends the adoption of the Report of the Committee on State Legislative Activities with its three Recommendations.

**Report of Committee on Impaired Physicians**

This has been a particularly busy year for the Committee on Impaired Physicians. The Committee has met every other month with numerous meetings of subcommittees in between regular meetings. The bulk of the Committee's work continues to be dealing with individual, troubled physicians, and regular meetings routinely last several hours. As the Committee's expertise expands, additional time is required, not only to deal with impaired individuals, but also to accomplish necessary associated administrative efforts.

Standing subcommittees are: liaison with the Auxiliary,



liaison with the medical schools, liaison with the Board of Medical Licensure, the publicity and speaker subcommittee, and the subcommittee on confrontation and aftercare. Each of these individual subcommittees constitutes a major activity in and of itself. In addition to these subcommittees, ad hoc committees meet at least every two months to deal with individuals who cannot be seen at regular meetings, and to meet with representatives of the Board of Medical Licensure.

As reported previously, the Committee has been exploring the possibility of developing a separate impaired physicians program office with a full-time medical director. A number of efforts were undertaken to pursue this goal. Contacts have been made with potential funding sources, which have primarily included liability insurance carriers. In addition, the Licensure Board has agreed to consider the possibility of providing funds for this effort through licensure registration fees. Contact has been maintained with other states to ascertain the organizational structure of their impaired physicians programs in relation to the medical association, governing authority, and expenditure relationships. Budgetary provisions have been prepared, and are revised as funding and operating events direct. All of these actions have been reported to and approved by the Board of Trustees, and the Committee has worked with the Board to maintain current information on its efforts in this regard.

The Committee has continued to serve as an advocate for impaired physicians with liability insurance carriers, the Board of Medical Licensure, hospital medical staffs, local colleagues, and state and federal administrative agencies. As the Committee's expertise becomes recognized, it seems apparent that the medical director program is a positive and necessary direction to pursue. Because of this expertise, more direct referrals have been received from the Licensure Board, hospital staffs, and groups of local physicians.

The relationship of the Committee with the Licensure Board continues on a sound footing with increased rapport and cooperation. This cooperation places a considerable responsibility on the Committee to the Board, as well as increased obligation to individuals with whom the Committee is working. Routine reports are generated to the Licensure Board, and are solicited from treatment modalities used in the impaired physicians process.

As the Committee has gained experience, it has identified the positive benefit of group and individual counseling in addition to traditional self-help group activities. A distinct group therapy process has been developed by the Committee and the results of that therapy process to date are very encouraging.

The Committee has also become involved this year in related but more oblique activities. As an example, there appears to be an emerging trend on the part of managed care plans to exclude physicians on the basis of acknowledged impairments. The Committee takes strong exception to this activity, and is currently working with the Licensure Board

and insurers to try to achieve some resolution. Given the fact that substance abuse is a disease and is treatable, exclusion from participation in an insurance plan on this basis is unreasonable.

In its ever-expanding role, the Committee has been called upon several times this year to intervene directly with impaired physicians and has been able to play a positive role in securing acute treatment, as well as fulfilling its more conventional role as an aftercare partner. With increased acknowledgement of the Committee's work, referrals continue to grow. It is a very positive comment on the abilities and dedication of the individual Committee members that this workload has been maintained to this point. The simple volume of work required, however, underscores the fact that the Committee's efforts need to be expanded even further.

Through the gracious contributions of the membership, the Committee continues to oversee and direct the Benevolent Fund, an accounting of which is available from the KMA auditor. In the past year, this fund has been used to assist individuals both with acute and prolonged treatment, has played an inestimable role in helping our colleagues with impairing problems.

It has been my personal privilege as Chairman to see the program grow and expand, both as an entity, and in its components, consisting of the Committee members. It is a tribute to the miracle of recovery that many of the individuals who first appeared for help have now become helpers. It is in this spirit of being "our brother's keeper" that we look forward to our continued work.

**Burns M. Brady, MD**  
**Chairman**

### **Recommendations, Reference Committee 3:**

Reference Committee No. 3 reviewed the Report of the Committee on Impaired Physicians, commends the Committee on the volume of work done, and recommends that KMA support efforts to develop a separate Impaired Physicians Committee Office with a full-time Medical Director. The Reference Committee recommends that Report No. 24 be filed.

## **Resolution G**

### **Definition of Surgery** **Warren County Medical Society**

WHEREAS, limited licensed practitioners continue to expand their scope of practice through legislative fiat; and

WHEREAS, legislation has been proposed in several states permitting nonphysicians to perform laser surgery which alters or disrupts human tissue; now therefore be it

RESOLVED, that surgery be defined under Kentucky law as any invasive procedure by any means which alters, pene-

trates, changes, or violates in any way human tissue, and includes preoperative and postoperative care for surgery; and be it further

RESOLVED, that KMA seek to have the definition of surgery added to Kentucky law permitting surgery to be performed only by physicians and osteopaths; and be it further

RESOLVED, that appropriate exemptions be established for dentists and podiatrists to the limit of their licenses, and that exceptions be granted to nurses and other allied health personnel to perform routine patient care activity such as injections, routine testing, etc, as prescribed by the attending or consulting physician.

**Recommendations, Reference Committee 3:**

Reference Committee No. 3 reviewed Resolution G, Definition of Surgery introduced by Warren County Medical Society. The Reference Committee heard testimony on Resolution G, and received input from the Board of Trustees. Because of difficulty in wording the definition of surgery, Reference Committee No. 3 submits the following Substitute Resolution with a new title:

**Subject: Performance of Laser Surgery**

WHEREAS, limited licensed practitioners continue to expand their scope of practice through legislative fiat; and

WHEREAS, legislation has been proposed in several states permitting nonphysicians to perform laser surgery which alters or disrupts human tissue; now therefore be it

RESOLVED, that the Kentucky Medical Association vigorously oppose any new legislation or administrative proposal to permit nonphysicians to perform laser surgery.

Reference Committee No. 3 recommends the Substitute Resolution be adopted in lieu of Resolution G.

**Resolution H**

**1990 Medicare Fee Discrimination  
Against New Physicians  
KMA Young Physicians Steering Committee**

WHEREAS, the Omnibus Budget Reconciliation Act (OBRA) 1990 instituted in January 1991 specific Medicare fee reductions for "new physicians" of 80% payment to all physicians in their first full calendar year of medical practice (equally discounting payments during the months practiced prior to that first January), and of 85%, 90%, and 95% to all physicians in their second, third, and fourth calendar years of practice, respectively; and

WHEREAS, even after the Resource-Based Relative Value Scale (RBRVS) implementation begins in 1992, these payment differentials will persist in law; and

WHEREAS, the AMA Council on Legislation has placed the elimination of this discriminatory policy as its Number 1 Legislative Priority; and

WHEREAS, Congressman Edolphus "Ed" Towns (D-NY) has introduced House Bill 1898 to repeal Medicare payment differentials for "new physicians;" and

WHEREAS, it is critical for each state and specialty society in the federation to join the AMA in the upcoming battle to ensure equitable payments for all physicians under RBRVS, now therefore be it

RESOLVED, that the Kentucky Medical Association strongly oppose the onerous provisions of OBRA 1990 which currently discriminate in payments to new physicians; and be it further

RESOLVED, that the Kentucky Medical Association establish the elimination of payment differentials for new physicians as a legislative priority for 1991 and beyond, if necessary, with the commitment of appropriate staff resources and Key Contacts; and be it further

RESOLVED, that the Kentucky Medical Association persistently encourage its Congressional Delegation to cosponsor House Bill 1898 and its companion Senate Bill when introduced.

**Resolution L**

**Fair Treatment of Physicians by the  
Federal Government  
Jefferson County Medical Society**

WHEREAS, the federal government, through its Medicare policies, has essentially frozen and reduced on several occasions not only reimbursements, but also the allowable amounts to be billed by physicians, unlike any other profession; and

WHEREAS, physicians' office expenses have continued to rise at a substantial rate due to personnel fees, supplies, and malpractice insurance; and

WHEREAS, physicians' administrative costs have risen markedly due to the proliferation of Health Care Financing Administration (HCFA) rules and regulations which shift much of the burden of administration into the physician's office; and

WHEREAS, Medicare patients receive letters from HCFA encouraging them to seek participating physicians as a cost-saving measure, although this claim may generally be misleading and erodes the physician-patient relationship; and

WHEREAS, most of the actual cost increases in Medicare are not due to physician fees, but instead due to expensive technological advancements and also due to the significant increase in administrative costs imposed by the federal government itself; and

WHEREAS, physician care accounts for only a small portion of the Medicare budget, yet provides the actual advo-



cacy of the patient in the health care system; now therefore be it

RESOLVED, that the Kentucky Medical Association encourage the American Medical Association to continue its support of anti-hassle legislation as it pertains to physicians and Medicare regulations; and be it further

RESOLVED, that the Kentucky Medical Association encourage the American Medical Association to work with HCFA and the United States Congress to attempt to reduce federal spending and deficits in health care through proportional emphasis on recently spiraling costs of administration, hospitalization, medication, and technology; and be it further

RESOLVED, that if these efforts fail, the Kentucky Medical Association will encourage the American Medical Association to pursue other approaches to these problems.

### Recommendations, Reference Committee 3:

Reference Committee No. 3 reviewed Resolution H, 1990 Medicare Fee Discrimination Against New Physicians, introduced by the KMA Young Physicians Steering Committee, and Resolution L, Fair Treatment of Physicians by the Federal Government, submitted by the Jefferson County Medical Society. Reference Committee No. 3 heard testimony from James B. Holloway, Jr, MD, Medical Director, Medicare Part B, and members of the Board of Trustees regarding Resolution H and Resolution L.

Reference Committee No. 3 recommends the adoption of Resolutions H and L.

## Resolution M

### Do Not Resuscitate Orders in the Pre-Hospital Setting Jefferson County Medical Society

WHEREAS, there is a growing recognition of the need to honor patients' autonomous decisions in the health care setting; and

WHEREAS, impediments for honoring such decisions exist in the pre-hospital setting, which can include nursing homes, Hospice programs, home health care systems, and emergency medical services; and

WHEREAS, in the pre-hospital environment no comprehensive or effective approach has been developed for honoring the decision of the terminally ill patient who does not wish to be resuscitated or to receive extraordinary life-prolonging treatment; and

WHEREAS, nursing home personnel and other pre-hospital professionals often seem unwilling or feel they are unable to follow documented wishes of a dying patient or the patient's family as regards DNR orders or the use of extraordinary means to prolong life; and

WHEREAS, there is insufficient legal protection for nursing homes and other pre-hospital care givers, including EMS

and ambulance services, desiring to honor patients' advance directives or DNR orders; and

WHEREAS, there exists in Kentucky no standard, clearly recognizable DNR or advance directive form which ambulance personnel or other health care professionals in the pre-hospital setting can feel legally secure in honoring; and

WHEREAS, medically inappropriate transfers may result in expensive, indiscriminate, and harmful efforts to prolong the agony of death; now therefore be it

RESOLVED, that the Kentucky Medical Association work with representatives of appropriate professional groups and organizations, as well as government and regulatory authorities, if necessary, to develop a uniform, coordinated, and rational approach with respect to the terminally ill patient who does not wish to be resuscitated or to receive extraordinary life-prolonging treatment in the pre-hospital environment; and be it further

RESOLVED, that one goal of this effort should be to develop a standard pre-hospital DNR form and to pursue statewide acceptance of this form by means of education; and be it further

RESOLVED, that the Kentucky Medical Association seek the necessary legislative and regulatory changes to protect the patient's right to self-determination, as well as to protect the activities of those health care professionals who follow such directives; and be it further

RESOLVED, that the Kentucky Medical Association work toward development of a statewide, standardized, reasonable method for the immediate identification of patients who have a valid DNR order in effect.

### Recommendations, Reference Committee 3:

Reference Committee No. 3 reviewed Resolution M, Do Not Resuscitate Order in the Pre-Hospital Setting, introduced by Jefferson County Medical Society. The Reference Committee heard testimony from the Jefferson County Medical Society and members of the Board of Trustees regarding Resolution M.

Reference Committee No. 3 recommends that Resolution M be adopted.

## Resolution V

### Publication of Rape Victims' Names KMA Resident Physicians Section

WHEREAS, rape is a crime of violence and many victims suffer post-traumatic-like stress syndrome, and

WHEREAS, reporting of rape victims' names by the news media adds to the psychological trauma suffered by the rape victim, and

WHEREAS, in a recently published poll most Americans agree that rape victims' names should not be publicized, now therefore be it

RESOLVED, that the Kentucky Medical Association support legislation that would prohibit the news and print media from making public the names of rape victims.

### **Recommendations, Reference Committee 3:**

Reference Committee No. 3, reviewed Resolution V, Publication of Rape Victims' Names, introduced by the KMA Resident Physicians Section.

Reference Committee No. 3 recommends the adoption of Resolution V.

## **Resolution X**

### **"Gag Rule" on Pregnancy Options Counseling Jefferson County Medical Society**

WHEREAS, the recent US Supreme Court *Rust v. Sullivan* decision upheld the Bush Administration's regulations that prohibit physicians and others working in federally funded family planning clinics from discussing all medical options available to a pregnant patient; and

WHEREAS, this so-called "gag rule" infringes on the basic doctor-patient relationship in that it dictates what physicians may and may not say to their patients; and

WHEREAS, this decision may place physicians in the untenable ethical position of either violating the law or failing to act in what may be the best medical interest of the patient; now therefore be it

RESOLVED, that the Kentucky Medical Association convey to the Kentucky Congressional Delegation its strong opposition to the Bush Administration's intrusion into the doctor-patient relationship by means of a "gag rule" limiting patient counseling in federally funded family planning clinics; and be it further

RESOLVED, that the Kentucky Medical Association urge the revocation of these regulations.

### **Recommendations, Reference Committee 3:**

Reference Committee No. 3 reviewed Resolution X, "Gag Rule" on Pregnancy Options Counseling, introduced by Jefferson County Medical Society. Your Reference Committee heard testimony from members of the Board of Trustees who explained the intent of this Resolution was not to take a stand on abortion but rather to oppose intrusion into the doctor/patient relationship.

Reference Committee No. 3 recommends that Resolution X be adopted.

Mr Speaker, Reference Committee No. 3 recommends the adoption of the report of Reference Committee No. 3 as a whole. Mr Speaker, I wish to thank the members of Reference Committee No. 3 for their participation in the review of these issues. Members of the Committee are Keith H. Crawford, MD, Paducah; Rachel R. Eubank, MD, Harlan; Beverly M. Gaines, MD, Louisville; and Thomas K. Slabaugh, MD, Lexington.

The Committee also thanks Jeanette Thompson for her assistance in the preparation of this report.

### **Respectfully submitted, REFERENCE COMMITTEE NO. 3**

**Scott B. Scutchfield, MD, Danville, Chairman**  
**Keith H. Crawford, MD, Paducah**  
**Rachel R. Eubank, MD, Harlan**  
**Beverly M. Gaines, MD, Louisville**  
**Thomas K. Slabaugh, MD, Lexington**

## **Report of the Chairman KEMPAC Board of Directors**

Thank you Mr Speaker, Members of the House of Delegates, and Guests: It is my privilege to report to you on the activities of the KEMPAC Board and organization during the 1990-1991 year. KEMPAC legally is a separate organization from the Kentucky Medical Association, because of election laws and financing related to those. However, it is not a separate function and it is a part of your organization. As part of that function our Board is appointed by the KMA Board. We now have 18 members on the Board, 2 from each Congressional District and 4 auxiliaries. The Board now consists of the First Congressional District of Larry Franks, MD; Hank Bell, MD, has been replaced by a new appointee Dan Miller, MD. In the Second Congressional District Salem George, MD, and Jerry Martin, MD, are your representatives; in the Third, Wayne Kotcamp, MD, and William VonderHaar, MD. The Fourth Congressional District representatives are Harry Carter, MD, and Ronald Levine, MD. In the Fifth Congressional District now representing you are William Pratt, MD, and Jim Crase, MD. From the Sixth Congressional District, Irene Minor, MD, continues, and my term has run out and I have been replaced by Preston Nunnelley, MD. In the Seventh Congressional District, the current representatives are Kenneth Hauswald, MD, and Jerry King, MD. The auxiliaries who are now serving on your Board are Fay Neal from Owensboro, Sugar Slabaugh from Lexington, and two new appointees, Barbara Haas from Northern Kentucky who replaced Kathy Mueller, and from Louisville, Angie DeWeese replacing Pat Schaefer.

Next year we do not know what exactly will happen. As you know, Kentucky will lose one Congressman, one US Representative. This will probably extensively reduce the KEMPAC Board to six Congressional Districts, 12 members plus four auxiliaries.

At the KEMPAC Board of Directors meeting yesterday, October 1, the Board elected its new officers for the coming year. Serving you will be Preston Nunnelley, MD, as Assistant Treasurer; Wayne Kotcamp, MD, as Treasurer; Jerry Martin, MD, as Secretary; Larry Franks, MD, as Vice Chairman; and for the next year Jerry King, MD, as Chairman.

KEMPAC has several functions which I would like to run



through with you for a moment. The main function, of course, is to raise money. The money we give to candidates comes from your pocket or your purse. We do depend on your voluntary contribution of dues. With your dues statement for the County Society, KMA, and AMA you will find a dues statement for KEMPAC. Please send your check back. The second function we have is political education. We are to keep you politically educated. Such a function as we had Monday night, the KEMPAC Banquet, is an educational function. I want to thank Sugar Slabaugh and Vicki Thorpe who made that banquet possible. The third function is to raise more money. We can't do anything without money to give away. The Board of Trustees as of yesterday only had one member who was not a member of KEMPAC. However, I want to thank those members of the House of Delegates who are members. Those 132 of you who are not members, I hope you would stop by the KEMPAC booth and join this week. Of course one of our vital functions is supporting candidates. We voted yesterday to support some candidates in the General Assembly, both in the Senate and the House of Representatives. We also voted some support on the request of two of our members for a judge candidate to the Court of Appeals. KEMPAC is very happy to respond to your request for support to a candidate if you would forward that request to us. Another one of our important functions is to raise more money. For those of you who have not joined yet, the booth is still open in the Convention Center or I will be glad to take your money tonight.

KEMPAC also relates to AMPAC, which is the American Medical Political Action Committee. All the money given to support candidates in Kentucky comes from your dues. If we select to recommend support for a Federal candidate to the Congress, we can obtain some money from AMPAC. Of the \$100 of your membership dues, \$50 goes to AMPAC and \$50 stays with KEMPAC. AMPAC has been very good in supporting our candidates for Congress. Next year is going to be a critical year in the United States and the United States Congress in particular. It is estimated that 80 members of the House of Representatives will retire. Partly due to redistricting, and partly because if they stay in office, any support funds which they may have accrued over the years have to be forfeited if they have been there 10 years. There will be many openings in the US House of Representatives and KEMPAC will need to be active. That plus redistricting will make a critical year for its activities.

In parting I want to say "Thank You," and don't forget that some of you still need to join this year. Thank you very much.

**David B. Stevens, MD**

*Editorial Note: Unless otherwise noted, the Reference Committee action on each Report and Resolution was accepted as printed. Any opposing action taken is stated in discussion following the item.*

## REPORT OF REFERENCE COMMITTEE NO. 4

**Andrew R. Pulito, MD, Lexington, Chairman**

26. Report of the Committee on Medical Insurance and Prepayment Plans
27. Report of the Committee on Claims and Utilization Review
28. Report of the PRO Advisory Committee
29. Report of the Committee to Investigate Changing Trends in Medicine
  - Resolution N — Health Care Leadership (Jefferson County Medical Society)
  - Resolution O — Large Quantity Prescriptions (Jefferson County Medical Society)
  - Resolution P — Medicare Supplement Regulations (Jefferson County Medical Society)
  - Resolution Z — Professional Review Organizations (Floyd County Medical Society)
  - Resolution AA — Pharmaceutical Samples (Calloway County Medical Society)

### ITEMS FOR CONSENT

Reference Committee No. 4 reviewed the following items and recommends they be filed, by consent of the House, without discussion:

26. Report of the Committee on Medical Insurance and Prepayment Plans — filed
  27. Report of the Committee on Claims and Utilization Review — filed
  28. Report of the PRO Advisory Committee — filed
- Mr Speaker, Reference Committee No. 4 recommends adoption of the Consent Calendar as a whole.

## Report of the Committee on Medical Insurance and Prepayment Plans

The Committee on Medical Insurance and Prepayment Plans met on two occasions this year, November 28, 1990, and May 22, 1991.

### *KMA-Endorsed Blue Cross and Blue Shield Group Plan*

The Committee reviewed the KMA group Blue Cross and Blue Shield experience from the past year and the proposed renewal rates for 1991.

There has been a decline in membership within the KMA group from 1700 participants in 1989 to 1637 this year. (1126 participants — #414 — Low Option; 511 participants — #835 — High Option).

Overall, utilization patterns in KMA's Employer Code 414 (Low Option) have been favorable. Overall data for Employer Code 835 (High Option) indicates the inpatient utiliza-

tion significantly exceeds the statewide averages in every category.

The Committee discussed the possibility of adding catastrophic coverage or reinsurance for claims exceeding a certain amount; for example, \$100,000. Blue Cross and Blue Shield representatives reported that they were getting similar requests from a number of other associations. Blue Cross and Blue Shield is discussing the possibility of a pooling mechanism where this type of insurance would be included in all coverages.

The proposal presented by Blue Cross and Blue Shield for KMA's group plan for the coming year, with benefits remaining the same as the previous year, reflected a 21% increase in premium rates for both the High and Low Option plans.

Representatives from Blue Cross and Blue Shield and the KMA Insurance Agency noted that the national average for premium increases by all insurance carriers in 1990-91 was 23%. They also indicated that the current Low Option plan is quite competitive with other companies but the High Option plan is not. However, the Committee felt there were some members who desired this type of coverage even at the high premium necessary to obtain it.

Representatives from the Agency indicated that customers are asking for flexibility in deductibles and some are inquiring about Option 2000. The Agency felt strongly that something must be done to broaden the pool of insured to stabilize rates.

After much discussion, the Committee unanimously agreed to recommend that the Board continue to offer Employer Code 414 (Low Option) with deductibles of \$300/\$900; continue to offer Employer Code 835 (High Option) with deductibles of \$300/\$900; and to offer Option 2000 with \$300/\$900 deductibles.

The Committee also voted to add medical underwriting for any new one-man groups coming in to the plan if acceptable to Blue Cross and Blue Shield.

At its August meeting, the Board approved the above recommendations made by the Committee. However, after receiving rates for the Option 2000 plan from Blue Cross and Blue Shield, it was learned that Option 2000 was not significantly less expensive than the current Low Option coverage, so the Committee decided not to include Option 2000 as an offering to the membership last year.

The Board asked the Committee to provide at least two other competitive bids for the KMA group when the plan is up for renewal in December 1991. The Committee has attempted to do that in the past and was unable to locate companies interested in writing our group. However, the Agency will pursue this option again.

Several meetings have taken place among Blue Cross and Blue Shield officers, representatives from the KMA Insurance Agency, KMA staff, and your Chairman regarding KMA's group plan. Blue Cross and Blue Shield has offered to cooper-

ate in developing a survey of current KMA members regarding their participation and/or nonparticipation in the group plan. The Committee will also look into other options and arrangements in an effort to expand our coverage pool and stabilize rates.

#### *Determination of Medical Necessity by Carriers*

Last year members of the Committee reported that carriers are disallowing claims for services based on their determination that the services were not medically necessary. As a result, the Committee asked the Executive Committee to seek a determination as to what entities have the authority and responsibility to determine medical necessity.

The Kentucky Board of Medical Licensure was requested to comment on whether or not it felt denial of payment by carriers based on medical necessity was the practice of medicine. The Licensure Board, through its attorney, felt that by entering into an insurance contract, patients agreed to accept the terms of those contracts which may exclude payment for certain services. The carriers are not saying the physician cannot perform the service; they are saying they will not pay for it if it is performed.

As insurers seek to restrict the number of services they cover and patients find they are paying for uninsured but necessary services, the problems will become more acute. The Committee believes the issue will ultimately be resolved in court.

#### *Blue Cross and Blue Shield Contract Analysis*

This year Blue Cross and Blue Shield revised its Participating Physicians Agreement. KMA's outside counsel prepared an analysis of the revised Agreement. The analysis was made available to the membership, on request, at no cost.

#### *Medical Management Resources/Electronic Billing*

Medical Management Resources (MMR) is a division of Blue Cross and Blue Shield of Kentucky responsible for the development and marketing of electronic claims and related equipment and services within the health care industry. Representatives of MMR demonstrated their products to the Committee and explained the various options in electronic billing now available.

The MMR products collect electronic claim information from diverse medical sources. Physicians may choose from several products designed to meet their needs ranging from point-of-service devices for lower volume submitters to fully configured office automation systems for the larger practice. Not only are claims gathered electronically, but the provider may also inquire about previously submitted data.

MMR's desire is for KMA to endorse the concept of electronic claims and its importance to physicians and MMR as a deliverer of electronic claims submission. The Committee suggested that physician focus groups be used to determine if electronic claims submission would be helpful to them.



## *Senate Bill 21*

The Committee was given a report on Senate Bill 21, enacted during the 1991 Special Session of the General Assembly. The federal government required Kentucky Medicaid to add approximately 100,000 new recipients but did not provide additional money for the expansion. The Medicaid Department estimated the expansion would result in a budget shortfall of \$27 million which, added to the federal match, would total around \$80 million.

The state had three options: (1) Reduce Medicaid reimbursement for physicians by 25-45%; (2) Raise \$80 million in new taxes; or (3) Incorporate options permitted under OBRA 90.

The General Assembly chose to enact the latter provision which allows states to tax physicians providing Medicaid services up to 15% of their Medicaid collections. That money would be pooled and used as matching funds, with physicians guaranteed a minimum of a one-for-one return and, in most cases, a two-for-one return. A more detailed account of the events of the Special Session, particularly HB 21, can be found in the Legislative Chairman's Report.

As Chairman, I appreciate the significant time, effort, and contributions made by the members of the Committee. These individuals work very hard on issues that have far-reaching implications on all physicians in Kentucky.

In addition, I appreciate the continuing cooperation and communication that we receive from Kentucky Blue Cross and Blue Shield and the Kentucky Department of Insurance.

**Donald R. Neel, MD**  
**Chairman**

## **Report of Committee on Claims and Utilization Review**

This year has again shown little solicited activity on the part of the Claims and Utilization Review Committee. As previously reported, in recent years the proliferation of managed care plans and the extensive profiles developed by governmental medical agencies have made fee review obsolete.

Quality of care issues arise episodically, but these, too, are primarily resolved through previous contractual arrangements between the major policyholder and the carrier.

Review activity at the district level is essentially sparse, with the exception of a few districts. Worker's Compensation claims have arisen from time to time, but the new Worker's Compensation law obviates the use of the KMA review system in this context.

Currently, there are pending approximately five major claims, which deal with policy matters rather than actual peer review. Specifically, these are associated with payment methodologies, the physician component of large hospital-based medical operations, and contract limitations applied to psychiatric treatments.

The Committee and the entire peer review system remain steadfastly committed to physician review by practicing physicians, yet independent review of the nature offered by KMA continues to be in diminishing demand. Appropriate directions for the peer review system continue to be sought and it is strongly felt that it should remain intact, at least until new directions are defined.

**K. Thomas Reichard, MD**  
**Chairman**

## **Report of the Pro Advisory Committee**

This year has seen considerable activity regarding peer review organizations (PROs), both nationally and at the state level. Beginning around the first of the calendar year, a marked increase was noted in the submission of quality point letters to practicing physicians by the PRO.

Over a period of some months, the Committee collected a number of complaints issued by members concerning quality denials. Upon investigation, it was seen that many of these denials appeared to relate to inappropriate or inadequate review on the part of the PRO.

At an April meeting, the Committee invited representatives of the Sentinel Medical Review Organization, along with the Secretary of the Floyd County Medical Society, a representative of the Pike County Medical Society, and two other interested physicians, to look into specific areas of potential harassment. The Secretary of the Floyd County Medical Society, Raghu Sundaram, MD, had been particularly diligent in canvassing members of the Society to determine difficulties encountered, and presented a plethora of information relating to those review activities.

The Committee noted specifically that much of the medical material considered indicated possible superficial review or inadequate analysis of information appearing in the medical records; what appeared to be unnecessary punitive attention by the PRO to specific physicians; and some possibly inequitable decisions made by PRO reviewers. A consensus at this meeting was that there appeared to be a lack of communication between the PRO and physicians, and that the PRO in some instances appeared to require unnecessary, superficial documentation. At the same time, in some cases physicians were not supplying adequate documentation.

In response, the Medical Director for Sentinel related that physician advisors are not instructed to adhere strictly to standard criteria, but are encouraged to use medical judgment, and that interventions made by Sentinel are not intended to be punitive, but an educational effort to assist physicians, particularly with regard to documentation. It was also related that many of the general review requirements contained in the PRO contract were specifically directed by the Health Care Financing Administration (HCFA) without

physician input at the level of genesis. It was agreed to accumulate additional information and to hold a subsequent meeting to make specific suggestions to Sentinel about improving the review and communication process with physicians.

At a subsequent meeting, information developed for corrective efforts on the part of Sentinel was considered with the intent to transmit this to the PRO. However, at this June meeting it was learned that some major changes had occurred that would have more significant and far-reaching effects than routine review efforts by Sentinel. It had been previously reported that the Fourth Scope of Work for PROs nationally (contract requirements for the 1991-1993 cycle) would bring considerable changes. In addition to intensified review, a process of data compilation using the Uniform Clinical Data Set (UCDS) is to be instituted. The UCDS would require that as many as a thousand bits of information be organized and developed into algorithms so that any episode of care will be analyzed to conform to the data set for a specific diagnosis and episode of illness. Because of this significant change, PROs would be required to modify operations extensively. These modifications would require not only much more intensified review than in the current Scope of Work, but will ultimately transform the review process into a routinized procedure requiring less direct medical input.

In the context of this knowledge, it was learned that the chief operating officer of the PRO for Kentucky has resigned, as had the Medical Director. Up to this point, the Committee had felt quite comfortable with the communications that had been established with Sentinel, in spite of many ongoing disagreements. The change in personnel at this critical juncture in the PRO program was felt to jeopardize the overall process.

Subsequently, it was learned that the new contract period would include a competitive bidding process, which meant that automatic renewal of the contract with Sentinel would not occur. It was also learned that because of the time frame involved in the competitive bidding process, regardless of what organization might win the contract, a period of as long as three months might ensue during which PRO operations would be held in abeyance.

Both of these issues — changes required in the Fourth Scope of Work and the contracting process — were presented to the Board of Trustees in April, and at the present time, it is not clear what the immediate future will bring for PRO operations in Kentucky. As previously stated, in spite of disagreements with Sentinel policies, a positive working relationship had been developed with Sentinel personnel. The Committee has concluded that its strongest role should be to closely follow the contract process and, subsequently, monitor even more closely the implementation of the Fourth Scope of Work.

Throughout the year, the Committee has appreciated the input of individual members, as well as more direct con-

certed efforts by the Floyd County Medical Society and the Jefferson County Medical Society.

**James M. Bowles, MD**  
**Chairman**

## **END OF CONSENT CALENDAR ITEMS**

### **Report of the Committee to Investigate Changing Trends in Medicine**

The Committee to Investigate Changing Trends in Medicine met on Wednesday, February 20, 1991.

The charge to the Committee is to study and report on evolving delivery and payment mechanisms; to study and report on demographic trends affecting medical practice; to study and report on ethical questions regarding financial considerations versus quality of life; to investigate trends in cost containment activities; and to determine, to the extent feasible, the role of organized medicine in this changing environment.

Some of the issues discussed and reported on by the Committee in the past are the growth of nontraditional payment systems; various cost containment issues; the future physician population; the nursing shortage; physician advertising; the changing demographics of Kentucky; our aging society; medical school demographics; health care rationing; and AMA Health Access America project.

#### *Rural Health Care*

At the Interim Meeting of the American Medical Association in December 1990, a great deal of emphasis was given to the problem of shortages of rural health physicians throughout the United States. Over the past several years, there has been a widespread concern that the United States may have an excess of physicians, especially by the year 2000, but revision of the GMENAC data has suggested that the excess will be far less than predicted. In the United States in 1987, there were 220 physicians per 100,000 population, and it is estimated that this number will increase to 239 per 100,000 population by the year 2000, a number projected to be sufficient or mildly excessive. In 1987, Kentucky had 159 physicians per 100,000 population.

Studies made of Kentucky physicians by KMA's Physician Manpower Committee indicate that Kentucky does not now have, nor is it expected to have, an excess of physicians in the near future, but it does have a problem with physician maldistribution. At the present time, Kentucky is rated sixth among states most underserved by rural physicians (behind Missouri, Texas, Oklahoma, Georgia, and Louisiana). In the United States at present, 26% of the population lives in rural areas while only 13% of physicians practice in rural areas.



Nationally, the total number of rural physicians has increased from 1977 to 1987, but the population of physicians entering rural practice has decreased. Forty percent of the counties in the United States with populations less than 5,000 have no physician.

Some of the problems in recruiting and obtaining rural physicians are: lower reimbursement rates; high liability premiums; professional isolation; lack of support equipment and staff; insufficient population and economic base; lack of cultural life; poor educational opportunities for children; spouse dissatisfaction and lack of job opportunities for spouses; heavy workload with lack of relief and cross coverage; and severe financial problems of rural hospitals resulting in closure.

Both medical schools in the state are encouraging students to apply for rural health care. A program is being implemented this fall which will involve 50-60 University of Louisville and University of Kentucky students from rural areas working with KMA members in local communities who will go into high schools to encourage enrollment in premedical courses and a career in medicine.

The issue of rural health care is a growing concern and the Committee was privileged to have Doctor Wayne Myers, Director of Rural Health Services, University of Kentucky Center for Rural Health, Hazard, to take part in the discussion of rural health care. Prior to coming to Kentucky, Doctor Myers was the Director of Rural Health for the states of Washington, Alaska, Montana, and Idaho.

One goal of Kentucky will be to establish a small research unit to track health problems unique to rural areas. A family practice residency will be established in Hazard as well as a Masters program for nurses and training opportunities for physical therapy and medical technology. The project will also work with the University of Kentucky in setting up emergency medicine residency programs in Corbin and Hazard.

The number of rural students going into medical schools has decreased. Studies indicate that approximately one-half of residents from rural areas return to practice in a rural area compared to 6% of the residents who describe themselves as originally from a metropolitan area. Starting salaries for physicians in rural and urban areas appear to be fairly competitive in Kentucky according to Doctor Myers. Physicians in rural areas see about 20% more patients per week than physicians in urban areas and will experience more nights on call and less time off for continuing education.

Eastern Kentucky was reported to have the same specialist and sub-specialist distribution that is recommended for the country overall. There are some areas that have no primary care doctors and the Center will work to determine whether or not it is reasonable to place primary care doctors in these smaller communities. It was reported that the number of medical students entering family practice residencies seemed to be decreasing, especially among US graduates,

due to economic and lifestyle issues. Medical schools are trying to encourage more physicians to go into primary care. For example, the University of Louisville requires students to do a four-week family practice rotation in a rural setting.

It was noted that health care delivery makes a large economic contribution to rural Kentucky and employs about 11% of the employed population. Unfortunately, some people are of the mind-set that medical expertise is superior in nonrural areas. The young, affluent population is more likely to seek care outside the community, so local rural providers often care for the elderly and the less affluent. Doctor Myers feels that rural communities need to support local caregivers if they expect care to be available in their community when it is needed.

One initiative under study concerns the feasibility of converting small rural hospitals to emergency care centers where patients could receive emergency care or could be kept overnight. However, some feel that most physicians would leave a community if their hospital closed and access to care would decrease since many rural people will not leave their area to get care.

Many approaches are being taken throughout the country to increase the number of rural physicians. It is generally agreed that the most effective strategies for recruiting future rural physicians continue to consist of selecting applicants from rural areas, preferably with spouses from rural areas, and providing continuing experiences in rural health throughout the undergraduate and graduate medical education process. It is very probable that state and local solutions will be more effective and long lasting than national efforts.

## *Managed Care Systems*

According to *The Current Managed Care Environment*, published by the American Medical Association, the concept of managed care applies to organized systems of health care as well as to a variety of techniques used by insurers, employers, and others to control cost and utilization. Managed health care systems, like health maintenance organizations (HMOs), integrate health care delivery, financing, and review in the provision of services to a defined population.

The AMA Board of Trustees has previously described "managed care" as systems or techniques "generally used by third-party payors expressly to provide what they consider an appropriate mix of medical and social services at the lowest possible cost to payors and patients." Managed care approaches frequently rely on economic incentives, for both physicians and patients, to control the utilization of health benefits.

A variety of managed care techniques are currently utilized by many insurers, employers, and managed care plans. Examples of such techniques include: managing medical costs and medical care concurrently; provider selection, monitoring, and organization; physician financial incentives and penalties; case management; and medical review. Some

systems, like HMOs, may implement a wide range of managed care techniques, while others, such as traditional insurance companies, may utilize only a few selected techniques.

Nationally, enrollment in health maintenance organizations grew from 8.2 million in 1979 to 33.1 million in 1990. The rate of growth in enrollees, however, has slowed considerably; 37% of the HMOs in a national sample reported that they had experienced an enrollment loss from 1988 to 1989. Approximately 14% of the US population is enrolled in an HMO.

The number of HMO plans has declined each year since reaching a peak of 662 plans in 1987. There were 575 HMO plans at the beginning of 1990. There has been a significant amount of consolidation in the HMO industry during the last three years. In terms of geographic distribution, as of 1984, every state in the country has an HMO plan.

The percentage of employers offering their employees the opportunity to join an HMO as part of a health benefit package has not changed since 1987, when approximately 62% of employers offered an HMO. On average, 33% of eligible employees enrolled in HMOs in both 1988 and 1989. It appears that many employers are unable to verify whether HMOs have resulted in any cost savings.

Data from the AMA's Center for Health Policy Research shed light on the extent of physician participation in managed care systems. The Center estimated that in 1989, 43.5% of all nonfederal physicians had at least one contract with a health maintenance organization. The participation of physicians in HMOs has steadily declined since peaking in 1987, when 47.2% of physicians participated in an HMO. During 1988, 46.6% of physicians had an HMO contract. Of those physicians who did participate in an HMO, 12.6% received at least half of their practice revenue from the HMO.

Currently in Kentucky, there are 11 active HMOs: ChoiceCare; HealthAmerica of Kentucky; HealthWise; HMO Kentucky; Humana Health Plan; MetLife; Alternative Health Delivery Systems, Inc. (formerly Partners); Lincoln National Health Plan of Ohio (formerly Peak Health Plan); PruCare; Southeastern Medical (Option 2000); and Humana Medical Plan. According to figures recorded at the Kentucky State Department of Insurance, all but one of these plans were profitable at the end of the quarter in September 1990.

Nationally, there were 660 PPOs at the beginning of 1989. Significant growth in PPOs began in 1983, and while growth in the number of new PPOs has slowed, the number of persons with the option to join a PPO has continued to increase. By the end of 1989, there were over 33.9 million people with a PPO option. While PPOs operate in Kentucky, they are not regulated by the Department of Insurance and detailed financial or operating information about them is unavailable.

Sponsorship and profit status changed during the 1980s. Many of the first PPOs were sponsored by physicians, hospitals, or as joint ventures among these groups. However, as

the industry has grown, it has attracted for-profit insurers and other investors. In recent years, more PPOs have been formed by insurers, and over 70% are organized as for-profit groups. Physicians and hospitals, although representing a large share of PPO sponsorship, have declined in market share in the last few years.

Although the available data show that employers are not expanding their use of HMOs, the percentage of employers offering a Preferred Provider Organization (PPO) has more than doubled in the past four years, rising from 15% in 1986 to 31% in 1989. In terms of cost containment, a survey done by A. Foster Higgins Company found that only 45% of employers with PPOs can quantify the effect of the PPO on costs, and of these firms, nearly half reported that the PPO had no effect on costs or had increased costs.

Available data on physician participation in PPOs nationally indicate that as of 1987, 43.3% of nonfederal physicians had a contract with a PPO. This number had increased from 1986, when 38.1% of physicians had a PPO contract. Physicians participating in a PPO indicated that revenue from these plans accounted for 12% of their total practice in 1987, and 10.2% in 1986.

At future meetings, the Committee will discuss AMA's Health Access America program; learn more about the implementation of the National Practitioner Data Bank; look at the issue of Practice Parameters; further discuss the issue of Health Care Rationing; and discuss the ethical issues surrounding physician ownership of Home Health Care companies.

As Chairman, I am grateful for the continuing support and participation of the members of the Committee and appreciate the time and expertise they provide to the membership.

**Robert R. Goodin, MD**  
**Chairman**

## **Recommendations, Reference Committee 4:**

Reference Committee No. 4 would like to commend the Committee to Investigate Changing Trends in Medicine for its excellent and thorough efforts on issues presented in its report. The subject of rural health care generated considerable discussion. The Reference Committee recommends that Report No. 29 be filed.

## **Resolution N**

### **Health Care Leadership Jefferson County Medical Society**

WHEREAS, medical care in the United States is among the best in the world; and



WHEREAS, the current health care delivery system is not universally available; and

WHEREAS, the health care delivery system is fragmented; and

WHEREAS, the American health care system is largely unplanned, lacking the framework with which to solve mutual problems, address costs, and channel resources where needed; now therefore be it

RESOLVED, that the Kentucky Medical Association take the lead in bringing together providers, business, insurers, government, and patients in a common effort to develop a framework within which to work on the broad problems facing the current health care system in Kentucky in a common effort, neutral in sponsorship, with vision for the common good.

#### **Recommendations, Reference Committee 4:**

Reference Committee No. 4 considered Resolution N, Health Care Leadership, introduced by the Jefferson County Medical Society, and recommends the following substitute RESOLVED be adopted in place of the existing RESOLVED:

**RESOLVED, that the Kentucky Medical Association assume a leadership role in participating in the task force to be appointed to follow up on recommendations proposed in the final report of the 1991 Kentucky Summit on Health Care Costs, which will bring together providers, business, insurers, government, and patients in a common effort to address the problems facing the current health care system in Kentucky.**

Reference Committee No. 4 recommends adoption of Resolution N as amended.

#### **Resolution N, adopted as amended, reads as follows:**

WHEREAS, medical care in the United States is among the best in the world; and

WHEREAS, the current health care delivery system is not universally available; and

WHEREAS, the health care delivery system is fragmented; and

WHEREAS, the American health care system is largely unplanned, lacking the framework with which to solve mutual problems, address costs, and channel resources where needed; now therefore be it

RESOLVED, that the Kentucky Medical Association assume a leadership role in participating in the task force to be appointed to follow up on recommendations proposed in the final report of the 1991 Kentucky Summit on Health Care Costs, which will bring together providers, business, insurers, government, and patients in a common effort to address the problems facing the current health care system in Kentucky.

## **Resolution O**

### **Large Quantity Prescriptions Jefferson County Medical Society**

WHEREAS, numerous insurance plans, particularly those covering retired employees, mandate that required medications be ordered in a three-month supply; and

WHEREAS, such policies frequently result in patients receiving 250-300 pills at a time; and

WHEREAS, the treating physician may not feel comfortable writing a prescription for such a large quantity due to the hazards of patient noncompliance or the potential injury of children or grandchildren through accidental ingestion in the home; and

WHEREAS, if the physician does not prescribe the medications as required, then the patients themselves, though on fixed incomes, may be required to pay, and therefore might be unable to obtain their needed medications; now therefore be it

RESOLVED, that the Kentucky Medical Association work with senior citizen groups, labor groups, business organizations, insurance companies, and the news media to discourage insurance requirements to prescribe medications in large quantities.

#### **Recommendations, Reference Committee 4:**

Reference Committee No. 4 reviewed Resolution O, Large Quantity Prescriptions, submitted by the Jefferson County Medical Society, and recommends its adoption.

## **Resolution P**

### **Medicare Supplement Regulations Jefferson County Medical Society**

WHEREAS, Medicare is a federally funded program to assure access of medical care to elderly citizens; and

WHEREAS, the United States Congress has adopted the National Association of Insurance Commissioners (NAIC) model regulations to standardize Medicare supplement policies; and

WHEREAS, the NAIC has included in its proposed Medicare supplement policies a Medicare-select option which allows managed care plans to offer Medicare supplement policies that restrict selection of providers while denying services out of network; and

WHEREAS, health insurance companies based in Kentucky have contacted the Health Care Financing Administration to offer this policy in Kentucky if approved as a participating state in the Medicare-select program; and

WHEREAS, misunderstanding of these restrictions by Medicare beneficiaries may lead to delays in care, disruption of the physician-patient relationship, and possible adverse

financial impact on those persons intended to be protected by Medicare; and

WHEREAS, the Insurance Commissioner of Kentucky has been lax in regulation and slow in response to patient and provider complaints concerning managed care Medicare supplements; and

WHEREAS, such policies tend to increase the cost of health care by encouraging use of higher-cost urban centers; now therefore be it

RESOLVED, that the Kentucky Medical Association propose and aggressively pursue legislation to exclude Kentucky's participation in the Medicare-select policy; and be it further

RESOLVED, that any Medicare supplement policies written by a health maintenance organization marketed in Kentucky conform to model regulations developed by the National Association of Insurance Commissioners (NAIC).

#### **Recommendations, Reference Committee 4:**

Reference Committee No. 4 next considered Resolution P, Medicare Supplement Regulations, introduced by the Jefferson County Medical Society. After considerable discussion, the Reference Committee recommends amendments to each of the existing RESOLVEDS.

The 1st RESOLVED would be amended as follows:

**RESOLVED, that the Kentucky Medical Association ~~propose and aggressively pursue legislation consider legislative, administrative, and regulatory methods to exclude Kentucky's participation in the Medicare-select policy; and be it further~~**

Reference Committee No. 4 recommends that the 2nd RESOLVED be amended as follows:

**RESOLVED, that it is the position of the Kentucky Medical Association that any Medicare supplement policies written by a health maintenance organization marketed in Kentucky should conform to the original model regulations developed by the National Association of Insurance Commissioners (NAIC) that require the policy to pay the minimums of Part A hospital deductible and 20% of Part B provider allowable charges.**

Reference Committee No. 4 recommends adoption of Resolution P as amended.

#### **Resolution P, adopted as amended, reads as follows:**

WHEREAS, Medicare is a federally funded program to assure access of medical care to elderly citizens; and

WHEREAS, the United States Congress has adopted the National Association of Insurance Commissioners (NAIC) model regulations to standardize Medicare supplement policies; and

WHEREAS, the NAIC has included in its proposed Medicare supplement policies a Medicare-select option which

allows managed care plans to offer Medicare supplement policies that restrict selection of providers while denying services out of network; and

WHEREAS, health insurance companies based in Kentucky have contacted the Health Care Financing Administration to offer this policy in Kentucky if approved as a participating state in the Medicare-select program; and

WHEREAS, misunderstanding of these restrictions by Medicare beneficiaries may lead to delays in care, disruption of the physician-patient relationship, and possible adverse financial impact on those persons intended to be protected by Medicare; and

WHEREAS, the Insurance Commissioner of Kentucky has been lax in regulation and slow in response to patient and provider complaints concerning managed care Medicare supplements; and

WHEREAS, such policies tend to increase the cost of health care by encouraging use of higher-cost urban centers; now therefore be it

RESOLVED, that the Kentucky Medical Association consider legislative, administrative, and regulatory methods to exclude Kentucky's participation in the Medicare-select policy; and be it further

RESOLVED, that it is the position of the Kentucky Medical Association that any Medicare supplement policies written by a health maintenance organization marketed in Kentucky should conform to the original model regulations developed by the National Association of Insurance Commissioners (NAIC), that require the policy to pay the minimums of Part A hospital deductible and 20% of Part B provider allowable charges.

## **Resolution Z**

### **Professional Review Organizations Floyd County Medical Society**

WHEREAS, some physicians are reluctant to provide services to Medicare patients with multiple problems, particularly if complications arise, and in view of minimal reimbursement; and

WHEREAS, many physicians continue to experience harassment from the professional review organization (PRO) because of a lack of adequate review, which then causes the physician to spend an inordinate amount of time researching medical records retrospectively in answering PRO inquiries relating to quality point issues; and

WHEREAS, a general improvement in communication between the PRO and physicians might resolve some of these problems; now therefore be it

RESOLVED, that the Kentucky Medical Association develop close communication with the PRO to help settle these disputes; and be it further

RESOLVED, that the Kentucky Medical Association work



to achieve local meetings between the PRO and physicians on a regular basis.

## Recommendations, Reference Committee 4:

Reference Committee No. 4 next reviewed Resolution Z, Professional Review Organizations, introduced by the Floyd County Medical Society. Reference Committee No. 4 recommends that Resolution Z be adopted.

## Resolution AA

### Pharmaceutical Samples Calloway County Medical Society

WHEREAS, pharmaceutical companies, through their respective representatives, provide physicians with needed samples in increasing numbers as more new products become available; and

WHEREAS, many of these product samples come in environmentally wasteful and redundant containers; and

WHEREAS, the disposal of these excessive containers in the form of trash significantly burdens local landfills; and

WHEREAS, this superfluous packaging of these samples can only result ultimately in increased patient cost; and

WHEREAS, we Kentucky physicians have a responsibility both to our environment and to our patients; now therefore be it

RESOLVED, that the Kentucky Medical Association use its office and influence with other state medical associations, the AMA, and the representatives of the pharmaceutical industry, to require the drug industry to adopt environmentally sound practices and policies regarding physician samples.

## Recommendations, Reference Committee 4:

Reference Committee No. 4 next considered Resolution AA, Pharmaceutical Samples, introduced by the Calloway County Medical Society. Reference Committee No. 4 shares the environmental concerns expressed in Resolution AA. However, the Reference Committee feels that it is inappropriate to single out the pharmaceutical industry, especially in view of the participation of drug companies in the Kentucky Physicians Care program and the benefits to our patients provided by drug samples. Reference Committee No. 4 recommends that Resolution AA be rejected.

## Recommendations, Reference Committee 4:

Mr Speaker, Reference Committee No. 4 recommends the adoption of the report of Reference Committee No. 4 as a whole.

I would sincerely like to thank the other members of the Committee: Gordon W. Air, MD, Crestview Hills; William H. Keller, MD, Frankfort; G. Irene Minor, MD, Berea; and

K. Thomas Reichard, MD, Louisville. I would also like to thank Martha Coombs for her assistance in the preparation of this report.

## Respectfully submitted, REFERENCE COMMITTEE NO. 4

**Andrew R. Pulito, MD, Lexington, Chairman**  
**Gordon W. Air, MD, Crestview Hills**  
**William H. Keller, MD, Frankfort**  
**G. Irene Minor, MD, Berea**  
**K. Thomas Reichard, MD, Louisville**

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*Editorial Note: Unless otherwise noted, the Reference Committee action on each Report and Resolution was accepted as printed. Any opposing action taken is stated in discussion following the item.*

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## REPORT OF REFERENCE COMMITTEE NO. 5

### Frank H. Catron, MD, Corbin, Chairman

30. Report of the Committee on Maternal and Child Health
31. Report of the Technical Advisory Committee on Physician Services (Title XIX)
32. Report of the Committee on Community and Rural Health
33. Report of the Committee on School Health, Physical Education, and Medical Aspects of Sports
- Substitute Resolution A — HIV Testing for Physicians: It's Now Time  
(McCracken County Medical Society)
- Resolution F — Medicare Implementation of RBRVS  
(Board of Trustees)
- Resolution J — Kentucky as a One-Fee Area  
(Harlan County Medical Society)
- Resolution Q — Health Education and Physical Fitness Testing in Kentucky Schools  
(Jefferson County Medical Society)
- Resolution R — Endorsement of AMA and CDC Recommendations Regarding Health Care Workers and Blood-Borne Pathogens  
(Jefferson County Medical Society)
- Resolution S — Medicaid Formulary  
(Jefferson County Medical Society)
- Resolution T — Prenatal Visit to Pediatrician or Family Physician  
(KMA Resident Physicians Section)
- Resolution Y — Voluntary Drug Testing in Schools  
(Floyd County Medical Society)

## ITEMS FOR CONSENT

Reference Committee No. 5 reviewed the following

items and recommends they be filed, as indicated, by consent of the House, without discussion:

30. Report of the Committee on Maternal and Child Health - filed

31. Report of the Technical Advisory Committee on Physician Services (Title XIX) -filed

Mr Speaker, Reference Committee No. 5 recommends adoption of the Consent Calendar as a whole.

## **Report of Committee on Maternal and Child Health**

Resolution R and Resolution Z were adopted by the 1990 House of Delegates and referred to the Committee on Maternal and Child Health. Resolution R and Resolution Z recommend ways to encourage education in the benefits of breastfeeding. Committee members concur that breastfeeding is the superior method of infant feeding and discussed ways to encourage expectant mothers to nurse. Patricia Nicol, MD, distributed pamphlets used by the state's Women, Infants, and Children (WIC) Program to encourage breastfeeding. Doctor Nicol pointed out that this information could be obtained from local health departments. Cynthia Harbaugh, MD, of Trover Clinic, the author of Resolution R, addressed the Committee regarding her interest in breastfeeding and the lack of support received by mothers.

The Committee recognized that the support of hospital staff, spouses, employers, and family members plays an important role in whether or not the mother is successful in breastfeeding. Many new mothers who have questions do not receive instructions on whom to call after they leave the hospital. It was the consensus of Committee members that education of the public regarding the advantages of breastfeeding is the most effective way to increase the incidence of its use. This education needs to begin in the doctor's office, hospital, and prenatal care classes.

The Committee discussed the report of the Southern Governors Association, Southern Legislative Conference, entitled "The South's Agenda for Healthy Infants and Families." This report is extremely supportive of expanding the role of mid-level practitioners, ARNPs, physician assistants, and midwives. It was pointed out that State Representative Tom Burch, Chairman of the House Health and Welfare Committee; Representative Ann Northup; and Senator Benny Ray Bailey, Chairman of the Senate Health and Welfare Committee, attended the conference. We note with interest that the report was compiled by individuals, most of whom are not involved in the actual delivery of infants. Any credible report should certainly involve those who are on the front lines, especially in the fields of obstetrics and pediatric, and who actually deliver the care. The chairman of the Kentucky Perinatal Association Legislative Committee expressed interest in KMA's input on sections applying to Medicaid reimbursement rates for obstetrical providers, subsidization of medical

malpractice insurance tied to participation in the medical program, and scholarship programs designed to attract and retain OB providers in underserved areas. According to the request, legislation is being drafted to implement the objectives of the report. Your chairman responded by requesting a meeting with the group to discuss the report in its entirety.

The Committee discussed substance abuse and the expectant mother. Committee members agreed that the expectant mother who is addicted needs help rather than incarceration.

The Committee also reviewed the growing shortage of obstetricians in Kentucky and the need for encouragement by family practice residency programs for residents to enter this training. In the coming year, the Committee will be contacting professional liability insurance companies in Kentucky to determine how many obstetricians each company insures. In addition, the medical schools will be contacted regarding their approach to obstetrics training for family practitioners.

On behalf of the Committee members, I wish to express our appreciation for the opportunity to serve. We look forward to working with the KMA Board of Trustees and the membership in the coming year.

**Danny M. Clark, MD**  
**Chairman**

## **Report of the Technical Advisory Committee on Physician Services (Title XIX)**

The KMA Technical Advisory Committee on Physician Services (Title XIX) experienced an extremely busy year with the introduction and implementation of House Bill 21, a major physician reimbursement bill, and the effects of the 1990 increase in physician reimbursement.

Added to the physician reimbursement budget in 1990 was \$18 million. The Technical Advisory Committee was charged by the KMA House of Delegates to determine reimbursement procedures for physicians and investigate why many physicians experienced reduced payments, even though additional money for physician services had been allocated under the Program. The TAC was asked to report its findings to the House of Delegates in 1991.

Resolution V, passed by the KMA House of Delegates in 1990, called for KMA to adopt a policy that reimbursement levels be proportionate to charges and level of skill and training and not discriminate against any class, specialty, or geographic location of physicians.

Resolution BB, also passed by the House in 1990, called for opposition to payment differentials to physicians and hospitals based on geographic location and called for KMA



policy to reflect that in the process of instituting single, equitable, statewide reimbursement schedules, insurance companies should not diminish any present reimbursement schedules.

The Technical Advisory Committee met several times with Roy Butler, Commissioner, and Janie Miller, Deputy Commissioner of the Department for Medicaid Services. The Commissioners explained that as a result of the \$18 million increase in physician reimbursement, there now exists a "level playing field" for all physicians, regardless of specialty or geographic area. The greatest portion (\$9.5 million) of the \$18 million went to inpatient services. The previous average payment for inpatient physician services was 20% of the amount billed. They explained that under the previous payment system, some doctors were receiving only 7% to 10% of their charges while others were being paid at 65%. Physician payment for inpatient services is now at 50% of the median charge for a given procedure based on 1989 charges.

Outpatient physician services were being paid in a somewhat similar way, with much variation, at a rough average of 50% of charges. This figure is now at 65% of the median charge for each procedure. Commissioner Butler explained that this leveled the scale for outpatient services with an increase for some and a decrease for others. Also, the previous 5% reduction for all patients, which occurred during the previous administration, has been restored using a portion of the \$18 million. Therefore, although some physicians' reimbursements decreased, most were raised substantially.

The Commissioners furnished printed charts to the Technical Advisory Committee showing outpatient and inpatient physician utilization and Medicaid reimbursement levels for the calendar year 1989 average payment versus July 1, 1990, payments. The charts demonstrated how payments had been equalized for all physicians who billed for the same procedure since August 1990. Each chart showed the payment now being made for that particular procedure, how many physicians had previously received a lower reimbursement for the procedure, and how many had previously received a higher reimbursement.

The Physician TAC felt satisfied with the Department's explanation, and a full report was made to the KMA Board of Trustees at its meeting on April 11, 1990.

At the request of the TAC, the Commissioners gathered information on the percentages of CPT codes being used for office visits and reported this information in the form of a pie graph. This material indicated the number of physicians who billed above or below the reimbursable amounts. For some 30 plus procedures on which the Commissioner furnished us information, the majority of physicians had billed below the prevailing amount. Medicaid reimbursement for all procedural codes is available from the Department for Medicaid Services upon request.

The Medicaid Program has been severely pressed because of the addition of some 60,000 new beneficiaries as a

result of new federal mandates caused by OBRA '90. The expanded rolls had an influence on the development of HB 21 (the Medicaid tax bill).

Since the first of the year, HB 21 has obviously consumed most of the attention of the TAC. Following the emergency session of the Advisory Council for Medical Assistance in December 1990 where a shortfall was announced, our Technical Advisory Committee and the Association held a number of discussions to try to provide some possible solutions.

HB 21 provided a solution that was radical at best. KMA did not actively oppose the bill, feeling that it provided the best of only a few distasteful alternatives. Fortunately, Secretary Cowherd and Mr Butler remained in close contact with KMA, and the TAC has been actively involved negotiating the implementation of the procedural aspects of HB 21. The Kentucky Medical Assistance Program will implement a physician fee update, effective for services provided on or after July 1, 1991, in conjunction with implementation of the tax assessment pursuant to HB 21.

The new upper limits for procedures performed on an outpatient basis are based on 100% of the 1989 median billed charges; new upper limits for inpatient services are based on 75% of the 1989 median billed charges.

The Department will increase the fee for deliveries, including cesarean sections, from \$650 to \$900. This fee applies to all specialties and is for both inpatient and outpatient deliveries.

The conversion factor will increase from \$15 to \$17 for anesthesia services. The upper limit fee for inpatient anesthesia services is set at 70% of the outpatient amount.

The Department announced that the fee list is currently being updated for printing and will be sent to all participating physicians in the near future. In the event some fees are not updated by July 1, 1991, a mass adjustment will be completed. Providers will not be required to resubmit the claims for this adjustment.

There will be no change in reimbursement for Medicare cross-over claims, lab procedures performed by physicians, and immunizations.

A method of taxing has been developed which assures that increased fees will amount to 200% of the tax levied on each provider. At the end of each calendar quarter, each provider will receive a tax notice from the Department. The tax will amount to one half of the benefit derived from the increased fees, not to exceed 15% of total revenues received during the quarter. On an *overall* basis, taxes amounting to 13% of Medicaid revenues will be needed to fund the increase. The tax will be applicable to all physicians participating in the Kentucky Medicaid Program.

Providers may submit a written request to the Department for reconsideration of the tax assessment determination within 20 days of receipt of the notice. If one or more providers submit a request, the Department shall hold a hearing



within 20 days from the last date on which reconsideration requests may be received.

The first tax bills will be mailed to providers on or about October 15, 1991. Tax payments will be due 45 calendar days from the end of each calendar quarter.

The KenPAC program continues to prove that Kentucky physicians are responding to the needs of the uninsured. There are 1,038 individual doctors participating in this program with an average of 200 patients per doctor. Most of those participating are primary care physicians, and access does not seem to be a problem since there are only eight counties with no primary care physicians.

Commissioner Butler noted that from the Department's standpoint, the KenPAC program is working well and that the money saved with this program was spent on budget overages before it was saved.

My appreciation is extended to other members of the Committee and to all physicians who participate in the Kentucky Medical Assistance Program.

**Harold L. Bushey, MD**  
**Chairman**

## **END OF CONSENT CALENDAR ITEMS**

### **Report of Community and Rural Health Committee**

The Community and Rural Health Committee met on two occasions this year. A major topic of discussion for the Committee was AIDS.

Reginald Finger, MD, Director, Division of Epidemiology, reported that the Cabinet for Human Resources has received \$300,000 funding for treatment of AIDS patients, including drugs, home health services, etc. This funding is also being used to pay insurance premiums for HIV positive patients who have lost their jobs because of illness and have the option to keep their insurance directly but do not have the funds to pay. This benefit is in compliance with COBRA. Patients may receive these benefits by contacting the Care Coordinator of their local health department, who certifies the necessity and then notifies CHR, who pays the insurance company directly. The Care Coordinator program is funded by a \$350,000 allocation directed by the Kentucky General Assembly.

Care Coordinators are social workers who are required to have a background in HIV treatment and are stationed in several state health departments. These coordinators are responsible for connecting HIV positive patients with all services available to them and following through with social services to see that patients receive all services. There are currently several patients using these services, but some opt

out because of concerns with confidentiality. On many occasions local health departments have anonymous contacts with patients before the patient actually provides name, address, etc. When patients become extremely ill they usually enroll in the program. There was concern about the possibility of uninsured HIV positive patients who lose their employment and seek services from the local health department. Doctor Finger informed the Committee that the Lead Coordinator would work with patients to enroll them into Social Security, disability, or Medicaid. Others can be eligible for the program on a sliding scale fee.

The Committee discussed the highly publicized case of the HIV positive Florida dentist (now deceased) who allegedly infected three patients. It was noted that the issue of testing physicians for HIV could become an issue at the 1991 KMA Annual Meeting and the 1992 Kentucky General Assembly.

The Committee met on a second occasion to specifically discuss HIV testing for physicians. After the Centers for Disease Control released its guidelines and the AMA adopted a position at its Annual Meeting in June, it became essential that KMA address the issue. As there had been some severe criticism in the health community that the State had no position, it became necessary to develop a position for KMA. The Committee reviewed the recommendations of the Centers for Disease Control (CDC) and the AMA Resolution in developing its own set of recommendations for presentation to the House of Delegates. The key to this entire problem is education of the public. The medical community is aware that the known risk of iatrogenic HIV transmission is extremely low, but recognizes the impact of the Florida dentist and the infected patients on the general public.

CDC adopted the following guidelines:

1. All HCWs should adhere to universal precautions, including the appropriate use of hand washing, protective barriers, and care in the use and disposal of needles and other sharp instruments. HCWs who have exudative lesions or weeping dermatitis should refrain from all direct patient care and from handling patient-care equipment and devices used in performing invasive procedures until the condition resolves. HCWs should also comply with current guidelines for disinfection and sterilization of reusable devices used in invasive procedures.
2. Currently available data provide no basis for recommendations to restrict the practice of HCWs infected with HIC or HBV who perform invasive procedures not identified as exposure-prone, provided the infected HCWs practice recommended surgical or dental technique and comply with universal precautions and current recommendations for sterilization/disinfection.
3. Exposure-prone procedures should be identified by medical/surgical/dental organizations and institutions at which the procedures are performed.
4. HCWs who perform exposure-prone procedures should



know their antibody status. HCWs who perform exposure-prone procedures and who do not have serologic evidence of immunity to HBV from vaccination or from previous infection should know their HBsAg status, and, if that is positive, should also know their HBeAg status.

5. HCWs who are infected with HIV or HBV (and are HBeAg positive) should not perform exposure-prone procedures unless they have sought counsel from an expert review panel and been advised under what circumstances, if any, they may continue to perform these procedures. Such circumstances would include notifying prospective patients of the HCWs seropositivity before they undergo exposure-prone invasive procedures.
6. Mandatory testing of HCWs for HIV antibody, HBsAg, or HBeAg is not recommended. The current assessment of the risk that infected HCWs will transmit HIV or HBV to patients during exposure-prone procedures does not support the diversion of resources that would be required to implement mandatory testing programs. Compliance by HCWs with recommendations can be increased through education, training, and appropriate confidentiality safeguards.

CDC defines exposure-prone procedures as follows:

Characteristics of exposure-prone procedures include digital palpation of a needle tip in a body cavity or the simultaneous presence of the health care worker's fingers and a needle or other sharp instrument or object in a poorly visualized or highly confined anatomic site. Performance of an exposure-prone procedure presents a recognized risk of percutaneous injury to the health care worker and if such injury occurs, the health care worker's blood is likely to contact the patient's body cavity, subcutaneous tissue and/or mucous membranes.

AMA Substitute Resolution 240 was adopted with the following Resolveds:

RESOLVED, that the American Medical Association support HIV testing of physicians, healthcare workers, and students in appropriate situations; and be it further

RESOLVED, that the AMA study the issues related to such testing including specifying situations in which testing should be performed, the frequency of testing, and the relationship of such testing to licensure, professional liability insurance, granting of privileges or any credentialing process with report back at I-91; and be it further

RESOLVED, that the AMA supports the position that HIV testing be done on physicians, other health care workers, and patients consistent with testing for other infections and communicable diseases; and be it further

RESOLVED, that the AMA encourage education of patients and the public about the limited risks of iatrogenic HIV transmission.

After considerable discussion, the Committee agreed to the following recommendations:

## Item No. 1 — HIV Testing for Physicians

- a. The Committee recommends that physicians who may be at risk for transmitting HIV disease by performing exposure-prone invasive procedures should know their HIV antibody status through voluntary testing on an annual basis.
- b. The Committee recommends that all physicians adhere to universal precautions.
- c. The Committee recommends the adoption of the CDC description of exposure-prone procedures and recommends that the Committee study the list of exposure-prone procedures when published by the AMA and report back to the House of Delegates in 1992.
- d. The Committee recommends that KMA oppose mandatory HIV testing of physicians.

## Item No. 2 — HIV Infected Physicians

- a. The Committee recommends that physicians infected with HIV refrain from performing exposure-prone invasive procedures as described by the Centers for Disease Control and the American Medical Association.
- b. The Committee recommends that a mechanism be devised by KMA whereby HIV infected physicians may receive adequate counseling, career modification advice, and other assistance as developed by a physician advocacy panel.
- c. The Committee recommends that KMA encourage education of patients and the public about the limited risks of iatrogenic HIV transmission.

There is great concern within the medical community with the problem of methicillin resistant *Staphylococcus aureus* infections (MRSA) and refusal of nursing homes to admit MRSA patients, and this issue drew a great deal of discussion.

Elderly patients are being transferred to hospitals from nursing homes with either colonization or active infection with MRSA. The Committee noted that requiring MRSA patients to remain in hospitals strictly because of MRSA colonization/infection is an extremely expensive way of treating patients and inappropriate. The Community and Rural Health Committee recommends that KMA meet with representatives of the Kentucky Association of Health Care Facilities and the Kentucky Hospital Association to seek resolution to the issue of hospitalizing or denying nursing home admission for MRSA diagnosed patients. The results of the meeting should be reported to the KMA Board of Trustees. In the event that the issue cannot be resolved, the Committee would urge that legislation be considered, if appropriate.

Doctor Finger discussed the current status of childhood immunizations being offered by CHR through the Department of Health Services. New legislation has been drafted to

include availability of additional immunization for children in day care and preschool as well as kindergarten. The following recommendation was adopted regarding the Kentucky Department of Health Services:

The Community and Rural Health Committee recommends that KMA express its appreciation to the Kentucky Department for Health Services for the excellent work it does for the children of Kentucky. The Committee commends the Department and the leadership of Reginald Finger, MD, MPH, Director, Division of Epidemiology, Department for Health Services.

The Committee also discussed the importance of physicians being trained in rural health care and noted the addition of a residency program in Hazard by the University of Kentucky College of Medicine. In the coming year we expect to focus more upon rural health care matters.

We thank the KMA Board of Trustees for being permitted to serve and urge members to refer relevant concerns to the Committee.

**Ardis D. Hoven, MD**  
**Chairman**

**RECOMMENDATIONS:**

1. The Community and Rural Health Committee recommends that KMA meet with representatives of the Kentucky Hospital Association to seek resolution to the issue of hospitalizing or denying nursing home admission for MRSA-diagnosed patients. The results of the meeting should be reported to the KMA Board of Trustees. In the event that the issue cannot be resolved, the Committee would urge that legislation be considered, if appropriate.
2. The Community and Rural Health Committee recommends that KMA express its appreciation to the Kentucky Department for Health Services for the excellent work it does for the children of Kentucky. The Committee commends the Department and the leadership of Reginald Finger, MD, MPH, Director, Division of Epidemiology, Department for Health Services.
3. On the issue of HIV disease and the physician, the Community and Rural Health Committee makes the following recommendations:

*Item No. 1 — HIV Testing for Physicians*

- a. The Committee recommends that physicians who may be at risk for transmitting HIV disease by performing exposure-prone invasive procedures should know their HIV antibody through voluntary testing on an annual basis.
- b. The Committee recommends that all physicians adhere to universal precautions.
- c. The Committee recommends the adoption of the CDC description of exposure-prone procedures

and recommends that the Committee study the list of exposure-prone procedures when published by the AMA and report back to the House of Delegates in 1992.

- d. The Committee recommends that KMA oppose mandatory HIV testing of physicians.

*Item No. 2 — HIV Infected Physicians*

- a. The Committee recommends that physicians infected with HIV refrain from performing exposure-prone invasive procedures as described by the Centers for Disease Control and the American Medical Association.
- b. The Committee recommends that a mechanism be devised by KMA whereby HIV infected physicians may receive adequate counseling, career modification advice, and other assistance as developed by a physician advocacy panel.
- c. The Committee recommends that KMA encourage education of patients and the public about the limited risks of iatrogenic HIV transmission.

**Substitute Resolution A**

**HIV Testing for Physicians: It's Now Time  
McCracken County Medical Society**

WHEREAS, all consumer polls indicate that physicians continue to lose public trust and political support; and

WHEREAS, surgeons — and for that matter, all physicians — are deeply concerned for their own health by unknowingly treating patients who are seropositive; and

WHEREAS, patients are deeply concerned by unknowingly being treated by surgeons and other physicians who are seropositive; and

WHEREAS, HIV tests may return false positive results and may cause unnecessary anguish and alarm, but, for the most part, are very accurate; and

WHEREAS, it remains true today that physicians could do much to ease public disappointment and frustration by going all out to demonstrate concern for patient, family, and community needs; now therefore be it

RESOLVED, that the KMA support interval physician testing for the HIV virus to protect the public from seropositive physicians; and be it further

RESOLVED, that the KMA support patient testing for the HIV virus.

**Resolution R**

**Endorsement of AMA and CDC Recommendations  
Regarding Health Care Workers and  
Blood-Borne Pathogens  
Jefferson County Medical Society**

WHEREAS, the acquired immune deficiency syndrome



(AIDS) is a potentially lethal condition with over 180,000 cases reported in the United States; and

WHEREAS, human immunodeficiency virus-type 1 (HIV-1), the causative agent of AIDS, has infected one million and is transmitted by blood and body fluids; and

WHEREAS, hepatitis B, another potentially lethal condition, is caused by another blood-and body fluid-borne pathogen, hepatitis B virus (HBV), infecting perhaps another million; and

WHEREAS, health care workers are potentially at risk for these infections; and

WHEREAS, infected health care workers engaged in exposure-prone invasive procedures may represent a risk to patients; and

WHEREAS, there is widespread public misinformation regarding potential risks for HIV-1 transmission from infected health care workers to patients; and

WHEREAS, although HIV-1 antibody testing is highly reliable, the possibility of false negative or false positive results exists; and

WHEREAS, the cost of mass HIV-1 screening is excessively high; and

WHEREAS, the Centers for Disease Control and the American Medical Association have issued recommendations for the prevention of transmission of HIV-1 and HBV in health care settings; now therefore be it

RESOLVED, that the Kentucky Medical Association endorse and adopt the current recommendations and guidelines issued by the Centers for Disease Control and American Medical Association with respect to health care workers and blood-borne pathogens, including the following principles:

1. Universal blood and body fluid precautions
2. Encouragement of voluntary HIV-1 testing for those involved in exposure-prone invasive procedures; opposition to mandatory testing
3. Hepatitis B vaccination
4. For those infected, appropriate practice modification with review/oversight by an appropriate body
5. Education of patients and the public about the limited risk of iatrogenic HIV-1 transmission

## Recommendations, Reference Committee 5:

Reference Committee No. 5 reviewed the Report of the Committee on Community and Rural Health and its Recommendations No. 1 and 2 which deal with denying nursing home admissions for MRSA-diagnosed patients, and expressing appreciation to the Kentucky Department for Health Services for its work with children, and recommends that both of these Recommendations be adopted.

The Reference Committee next reviewed Recommendation No. 3 of the Report of the Committee on Community and Rural Health; Substitute Resolution A — HIV Testing for Physicians: It's Now Time, submitted by McCracken County

Medical Society; and Resolution R — Endorsement of AMA and CDC Recommendations Regarding Health Care Workers and Blood-Borne Pathogens, submitted by the Jefferson County Medical Society.

The Reference Committee recommends that Recommendation No. 3 of the Committee on Community and Rural Health be adopted in lieu of Substitute Resolution A and Resolution R.

The Reference Committee further recommends that because of the relationship of HIV and Hepatitis B infections, Hepatitis B vaccinations should be available to all health care workers.

The motion was seconded from the floor. C. R. Dodds, MD, Delegate from Hopkins County, was recognized, who made a motion to amend by deletion of the phrase, "because of the relationship of HIV and Hepatitis B infections." The motion was seconded and carried.

**The final paragraph of the Reference Committee's recommendations would then read as follows:**

**The Reference Committee further recommends that Hepatitis B vaccinations should be available to all health care workers.**

## Report of the Committee on School Health, Physical Education, and Medical Aspects of Sports

The Committee on School Health, Physical Education, and Medical Aspects of Sports met on three occasions during the Associational year. The major focus during the year was the continued development and refinement of the KMA Sports Medicine Symposia throughout Kentucky. The symposia served to educate high school athletic team and cheerleading coaches on medical, safety, and health issues.

The following criteria, approved by the KMA Board of Trustees, were developed by the Committee as guidelines for educational or medical institutions wishing to conduct sports medicine seminars for high school athletic coaches:

1. Requests must be received nine months preceding proposed meeting date.
2. The final program must be presented to the Committee four months prior to the scheduled seminar for approval or disapproval.
3. All applicants must follow a format for programs which will be provided to them. The format will include:
  - A. Requirement that a physician licensed by the Kentucky Board of Medical Licensure sponsor the seminar.
  - B. Attendees must be notified that they must be certified annually for CPR.
  - C. All programs must include a statement that the seminar is sanctioned by the Kentucky Medical Association Committee on School Health, Physical Educa-

tion, and Medical Aspects of Sports, the Kentucky High School Athletic Association, and the Kentucky Department of Education.

D. All programs will be reviewed to ensure:

1. Appropriate subject matter.
2. Qualification of speakers.
3. Equitable cost to attendees; eg, \$15 for seminar. May charge or get sponsor for extra costs — must identify extra costs.
4. Adequate hours of CSME (7 hours minimum).
5. No duplication of content (as compared to prior years).
6. Coordination of conference dates and sites with other sports medicine seminars.

Subject matter must be chosen from the following:

1. Conditioning for sports participation
2. Pre-participation exam
3. Proper use of protective sports equipment
4. Matching of athletes based on physical maturation, personality, and sex
5. Soft tissue injuries in sports
6. Skeletal injuries in sports
7. Taping and bracing of muscular/skeletal injuries
8. On-the-field treatment of muscular/skeletal injuries
9. Management of medical disorders in athletes; eg, diabetes, epilepsy, etc.
10. Neurological injuries
11. Rehabilitation of muscular/skeletal injuries
12. Special problems of the female athlete
13. Nutrition and the athlete
14. Use and abuse of drugs in athletes
15. Skin problems of athletes (non-trauma)
16. Discussion of special senses — eyes and ears

Special thanks go to Ronald E. Walldridge, MD, Chairman of the sub-committee which developed and presented the guidelines. The criteria, approved by the Board of Trustees at its meeting on December 13, 1990, become effective for the 1992 symposia. However, symposia chairpersons were encouraged to adhere to the guidelines as closely as possible for the 1991 programs.

The following Sports Medicine Symposia were set for 1991:

May 18	Elizabethtown Surgical Center
June 1	Shelbyville UMC Complex
June 1	University of Louisville
June 7	Murray-Calloway County Hospital
June 8	Kentucky Wesleyan College
June 21	Trover Clinic
June 22	Eastern KY University
June 28	Lexington Hyatt Regency
June 29	Paintsville Carriage House
July 19 & 20	Northern KY University
August 11	Lexington
The Committee reviewed the new State Department of	

Education regulations regarding cheerleader coaches, which became effective October 14, 1990. These regulations state that high school cheerleading coaches shall, by December 31, 1992, attend a separate, KMA-sanctioned sports medicine symposium on cheerleader injuries, and shall attend one symposium every two years after initial attendance. Mary L. Ireland, MD, agreed to have a separate symposium for cheerleader coaches in 1991, and other chairpersons agreed to have a separate break-away session for cheerleader coaches in 1991. The Kentucky Association of Pep Organizations (KAPOS) and the Kentucky High School Athletic Association (KHSAA) were notified of the dates. While CPR will not be included in all the symposia, coaches and trainers must be recertified on an annual basis.

At the Committee's request, the KMA Board of Trustees appointed a representative of KHSAA and the Kentucky Department of Education as ex officio members of this Committee to attend meetings regularly for the purpose of joint communication.

The Committee was notified this year that some insurance companies no longer insure systems who use student athletic trainers due to legalities and liabilities. The General Counsel for the Department of Education stated there was no statutory law or state regulation governing student athletic trainers and that guidelines used in establishing limits and liabilities of student athletic trainers should be based upon those set forth in a school district's insurance coverage contract.

In an effort to prevent illness and injury to athletes, the Committee has worked with KHSAA in implementing regulations delaying high school football practice with equipment until August 1, with games being played beginning August 30. However, for the 1991-92 season KHSAA has approved an additional game to be played on August 23 on a voluntary basis as a fund raiser for the KHSAA Hall of Fame. The Committee noted that this game is in conflict with previous regulations. The Committee deplores this action and has expressed its opposition to KHSAA and urged reconsideration of the date of the game for 1992.

The following are referrals to the Committee from the 1990 House of Delegates:

1. Reference Committee No. 5 commended the Committee for its work and recommended the following action, which was adopted by the House: "Because of some of the dietary advice being given to students by coaches and trainers, Reference Committee No. 5 suggests that the Board of Trustees ask the Committee on School Health, Physical Education, and Medical Aspects of Sports to investigate providing information to high school coaches and trainers regarding appropriate nutrition. Existing sources could be utilized for obtaining this information."

The Committee noted that proper nutrition is currently being included in the Sports Medicine Symposia. A packet of additional information has been written and will be avail-



able for symposia chairpersons. The Committee agrees that this is a worthwhile project and commends the House of Delegates for its recommendation.

2. The 1990 Committee on State Legislative Activities adopted a recommendation relating to corporal punishment in schools. That recommendation is as follows: "The Committee on State Legislative Activities recommends that the Board of Trustees refer the issue of corporal punishment in schools to an appropriate committee for study and that a report of its findings be presented to the 1991 House of Delegates."

The Committee discussed this issue and notes that since the referral the State Board of Education adopted regulations banning corporal punishment in schools. Correspondence received from the Kentucky Pediatric Society stating their opposition to this measure was also reviewed, as well as AMA's position of opposition. Considering this information, the following motion was adopted:

The Committee on School Health, Physical Education, and Medical Aspects of Sports recommends the adoption of the position of the American Medical Association on the issue of corporal punishment in schools.

AMA's position can be summarized as follows:

The AMA (1) supports the abolition of corporal punishment in schools; (2) encourages universities that train teachers to emphasize alternative forms of discipline during their training; (3) encourages physicians to work toward the abolition of corporal punishment in their communities; (4) encourages state medical societies to support legislation prohibiting corporal punishment in their state; (5) encourages parents and school personnel in those districts that have abolished corporal punishment to ensure the implementation of existing policies; (6) supports providing information to physicians and medical societies for use in the abolition of corporal punishment; and (7) supports working with the American Academy of Pediatrics to implement these policies.

3. Resolution S — Mandatory Drug Testing for all High School Students — urged the introduction and passage of appropriate legislation to require mandatory drug testing for high school students. The Committee discussed the feasibility of testing all high school students for drug use.

J. Michael Ray, MD, submitted to the Committee a plan for surveying high school administrators and students regarding substance abuse testing in the high school setting. This research will be a year-long study and require financial backing. The Committee adopted the following motion:

The Committee on School Health, Physical Education, and Medical Aspects of Sports requests that the KMA Board of Trustees support and endorse the research plan presented by J. Michael Ray, MD, and provide funding of \$760 to implement the plan.

KMA subsequently approved our request and the study is under way. It was the consensus of the Committee that it

is not economically feasible to test all high school students for drug use. Historically, the Committee has provided information, including pamphlets on drug use, Sports Medicine Syllabuses for Coaches, and seminars, regarding the dangers of drug abuse, and continues its ongoing research and education concerning this problem.

The passage of HB 443 by the 1990 Kentucky General Assembly was discussed. HB 443 permits students in grades seven and eight to participate in high school sports and more than one school-sponsored team at the same time in the same sport. The Committee believes this bill promotes competition between undeveloped children 13 and 14 years of age with 18 year olds and, more importantly, has the potential, particularly in heavy contact varsity sports where protective equipment is worn, to severely injure and possibly cause the death of small children. The following recommendation was adopted:

The Committee on School Health, Physical Education, and Medical Aspects of Sports recommends that HB 443 be amended to prohibit students in grades seven and eight from participating in varsity soccer, football, and wrestling. The Committee urges KMA to work with the Kentucky High School Athletic Association, the Committee on School Health, Physical Education, and Medical Aspects of Sports, and the Kentucky General Assembly in developing legislation to meet this objective.

The Committee has had an extremely busy year and thanks all physicians for their cooperation with the Committee and its stated purpose of improving the health and safety of our school children. We look forward to the future and express our gratitude for the opportunity to serve the profession and the public.

**R. Quin Bailey, MD**  
**Chairman**

## RECOMMENDATIONS:

1. The Committee on School Health, Physical Education, and Medical Aspects of Sports recommends that HB 443 be amended to prohibit students in grades seven and eight from participating in varsity soccer, football, and wrestling. The Committee urges KMA to work with the Kentucky High School Athletic Association, the Committee on School Health, Physical Education, and Medical Aspects of Sports, and the Kentucky General Assembly in developing legislation to meet this objective.
2. The Committee on School Health, Physical Education, and Medical Aspects of Sports recommends the adoption of the position of the American Medical Association on the issue of corporal punishment in schools.

**Recommendations, Reference Committee 5:**

Reference Committee No. 5 reviewed the Report of the Committee on School Health, Physical Education, and Medical Aspects of Sports and its two Recommendations. The Reference Committee recommends that the report and both Recommendations be adopted.

**Resolution F**

**Medicare Implementation of RBRVS  
Board of Trustees**

WHEREAS, the Federal Government adopted a phased-in implementation of the Resource-Based Relative Value Scale (RBRVS) as a payment methodology for physician reimbursement under Medicare; and

WHEREAS, it was clearly stated in discussion with physicians around the country that RBRVS implementation would be budget-neutral, and was not intended as a method of cost containment or cost control; and

WHEREAS, the Federal Government, through its regulatory agencies, has now indicated that its implementation phase (beginning in January 1992) will include features that are not budget-neutral, but significantly curtail appropriate physician reimbursement across the entire spectrum of physician payment; and

WHEREAS, the Federal Government is assuming a behavioral adjustment factor in its conversion factor by assuming, without appropriate scientific data, that physicians will arbitrarily and capriciously increase the volume of service to compensate for a decrease in specific payments for given services; and

WHEREAS, the implementation of the RBRVS, as currently envisioned by the Federal Government, would have the potential to significantly reduce physician reimbursement for care under the Medicare program for all providers irrespective of specialty or location; and

WHEREAS, the Kentucky Medical Association, being concerned with the proposed implementation procedures, immediately dispatched a delegation of officers and staff to Washington to personally voice KMA's concerns with Kentucky's Congressional delegation; and

WHEREAS, KMA followed that visit with correspondence and telephone calls, and encouraged individual members of the Association to contact their Senators and Representatives to voice their dismay over the proposal; and

WHEREAS, KMA is maintaining ongoing communication with Kentucky's Congressional delegation and KMA's membership in an effort to demonstrate the importance of this issue to physicians and patients, now therefore be it

RESOLVED, that the Kentucky Medical Association, in conjunction with other state associations and the American

Medical Association, continue to communicate with Congressional leaders to obtain revisions in the RBRVS implementation for Medicare reimbursement so the implementation shall be budget-neutral and reflect the reasonable readjustment of physicians' payments as originally proposed by the Federation and agreed to by Congress.

**Recommendations, Reference Committee 5:**

Reference Committee No. 5 considered Resolution F, Medicare Implementation of RBRVS, introduced by the Board of Trustees, and heard testimony regarding this Resolution.

Reference Committee No. 5 recommends that Resolution F be adopted.

**Resolution J**

**Kentucky as a One-Fee Area  
Harlan County Medical Society**

WHEREAS, physicians with equal training and qualifications should not be discriminated against because of where they live in Kentucky; and

WHEREAS, it costs as much or more to practice medicine in non-metropolitan areas as in metropolitan areas; and

WHEREAS, there is a physician shortage in rural areas and not in metropolitan areas; and

WHEREAS, the government is now controlling medical fees as well as allowables, which will more and more hurt rural areas because of the indexes upon which allowables are adjusted; and

WHEREAS, the Kentucky State Legislature has enacted legislation establishing Kentucky as a one-fee area with respect to Medicaid payments, yet the Health Care Financing Administration directs Medicaid deductibles and coinsurance for Medicare to be paid on a three-area basis, thus causing inequities in combined Medicaid-Medicare cases; and

WHEREAS, the Kentucky Medical Association has previously adopted a Resolution recommending a one-fee area; and

WHEREAS, the Kentucky Medical Association should promote fairness and help put an end to this discrimination; now therefore be it

RESOLVED, that the Kentucky Medical Association endorse the concept that Kentucky be treated as a one-free area, notify the membership of this fact, and encourage its members to vote for Kentucky being a one-fee area.

**Recommendations, Reference Committee 5:**

Reference Committee No. 5 considered Resolution J, Ken-



tucky as a One-Fee Area, introduced by the Harlan County Medical Society, and recommends that the following wording be added to the end of the existing "Resolved":

**RESOLVED, that the Kentucky Medical Association endorse the concept that Kentucky be treated as a one-fee area, notify the membership of this fact, and encourage its members to vote for Kentucky being a one-fee area, paid at area one fee levels.**

Reference Committee No. 5 recommends the adoption of Resolution J, as amended.

William H. Mitchell, MD, Delegate from Madison County and Chairman of the Rural Caucus, was recognized, who proposed a Substitute Resolved from the Rural Caucus to the Reference Committee's recommendation, as follows:

**RESOLVED, that the Kentucky Medical Association reaffirm the concept that Kentucky be treated as a single reimbursement area, and that in the process of instituting single, equitable, and statewide reimbursement schedules, third-party payors should not diminish any present reimbursement schedules.**

The motion was seconded from the floor and carried.

**Resolution J, adopted as amended by the House, reads as follows:**

WHEREAS, physicians with equal training and qualifications should not be discriminated against because of where they live in Kentucky; and

WHEREAS, it costs as much or more to practice medicine in non-metropolitan areas as in metropolitan areas; and

WHEREAS, there is a physician shortage in rural areas and not in metropolitan areas; and

WHEREAS, the government is now controlling medical fees as well as allowables, which will more and more hurt rural areas because of the indexes upon which allowables are adjusted; and

WHEREAS, the Kentucky State Legislature has enacted legislation establishing Kentucky as a one-fee area with respect to Medicaid payments, yet the Health Care Financing Administration directs Medicaid deductibles and coinsurance for Medicare to be paid on a three-area basis, thus causing inequities in combined Medicaid-Medicare cases; and

WHEREAS, the Kentucky Medical Association has previously adopted a Resolution recommending a one-fee area; and

WHEREAS, the Kentucky Medical Association should promote fairness and help put an end to this discrimination; now therefore be it

**RESOLVED, that the Kentucky Medical Association reaffirm the concept that Kentucky be treated as a single reimbursement area, and that in the process of instituting single, equitable, and statewide reimbursement schedules, third-party payors should not diminish any present reimbursement schedules.**

## Resolution Q

### Health Education and Physical Fitness Testing in Kentucky Schools

#### Jefferson County Medical Society

WHEREAS, there is currently no uniform, standard policy regarding health education and physical fitness testing in schools in Kentucky; and

WHEREAS, there is significant parental support for demonstrable student proficiency in health education and physical fitness, as demonstrated by a recent survey by the Kentucky Council on School Reform; and

WHEREAS, early introduction of health education and physical fitness is basic to a child's education and future health; now therefore be it

**RESOLVED, that the Kentucky Medical Association take action to encourage uniform health education and physical fitness proficiency testing in all schools.**

## Recommendations, Reference Committee 5:

Reference Committee No. 5 considered Resolution Q, Health Education and Physical Fitness Testing in Kentucky Schools, introduced by Jefferson County Medical Society, and recommends that Resolution Q be adopted.

## Resolution S

### Medicaid Formulary

#### Jefferson County Medical Society

Whereas, the current Kentucky Medicaid formulary offers only aspirin or Tylenol combined with codeine for the treatment of a wide range of pain syndromes; and

WHEREAS, under current guidelines for preauthorization of analgesics, requests for other analgesics are approved only for cancer, AIDS, spinal cord injury, and rehabilitation patients up to a period of six months; and

WHEREAS, the availability of such a narrow category of medications fails to address treatment of the pain of kidney stones, ruptured discs, burns, fractures, or severely strained muscles, and does not begin to address the needs of those patients who are allergic to or abusive of the drug codeine; and

WHEREAS, a physician is unable to prescribe other analgesics such as Darvon, Darvocet-N 100, Talwin, Vicodin, or even plain Tylenol as an alternative to codeine compounds for treatment of moderate pain in patients who are unable to afford such medications; and

WHEREAS, patients who tend to abuse the codeine compounds, or those who have adverse reactions to or side effects from, but have a legitimate need for pain medication, leave the physician with no alternative but to prescribe the codeine compound, thereby placing both the physician and

the patient at risk; now therefore be it

RESOLVED, that the Kentucky Medical Association urge the Kentucky Medicaid Formulary Committee and the administrative staff of the state Medicaid program to include a wider variety of pain medications in the Medicaid formulary in order to provide physicians greater discretion in the treatment of moderate pain, while avoiding adverse (allergic) reactions to or abuse of the codeine compounds which currently are the only analgesics available to their Medicaid patients; and be it further

RESOLVED, that the Kentucky Medical Association solicit other suggestions from physicians with respect to improvement of the Medicaid formulary.

**Recommendations, Reference Committee 5:**

Reference Committee No. 5 considered Resolution S, Medicaid Formulary, introduced by the Jefferson County Medical Society, and heard considerable testimony regarding this Resolution.

Reference Committee No. 5 recommends that Resolution S be adopted.

**Resolution T**

**Prenatal Visit to Pediatrician or Family Physician  
KMA Resident Physicians Section**

WHEREAS, the medical literature states that breast-fed infants have lower morbidity and mortality than do formula-fed infants, and

WHEREAS, the support education and promotion of breastfeeding is usually done by the pediatrician or family physician caring for the newborn infant, now therefore be it

RESOLVED, that KMA encourage Kentucky's obstetricians and family physicians who provide OB care to strongly encourage prenatal patients to meet with their pediatricians or family physicians of their choice prior to delivery so that patient education might be provided in such areas as breastfeeding, preventive care, and care of the newborn infant.

**Recommendations, Reference Committee 5:**

Reference Committee No. 5 considered Resolution T, Prenatal Visit to Pediatrician or Family Physician, introduced by the KMA Resident Physicians Section, and recommends that the following wording be added to Resolution T:

**RESOLVED, that KMA encourage Kentucky's obstetricians and family physicians who provide OB care to strongly encourage prenatal patients to meet with their pediatricians or family physicians of their choice prior to delivery so that patient education might be provided in such areas as breastfeeding / preventive**

**care, and care of the newborn infant to receive education prior to delivery in areas such as breastfeeding, preventive care, and care for newborn infants.**

Reference Committee No. 5 recommends that Resolution T be adopted as amended.

William H. Mitchell, MD, Delegate from Madison County and Chairman of the Rural Caucus, made a motion on behalf of the Rural Caucus that the Reference Committee's wording be rejected, and that Resolution T be adopted as originally submitted. Cecil D. Martin, MD, Chairman of the Board of Trustees, advised the House that the Board concurred with this motion; and the author of Resolution T, Baretta Casey, MD, discussed the intent of the Resolution as originally submitted.

**On a call for the vote, Resolution T, as originally submitted, was adopted.**

**Resolution Y**

**Voluntary Drug Testing in Schools  
Floyd County Medical Society**

BE IT RESOLVED, that the Kentucky Medical Association explore means to fund a program of voluntary drug testing in schools; and be it further

RESOLVED, that KMA act as a coordinating agency to develop voluntary collaboration in local communities among physicians, laboratories, and local support services to provide free services to implement this program.

**Recommendations, Reference Committee 5:**

Reference Committee No. 5 considered Resolution Y, Voluntary Drug Testing in Schools, introduced by Floyd County Medical Society, and recommends that it be referred back to the Board of Trustees for further consideration.

Mr Speaker, Reference Committee No. 5 recommends the adoption of the report of Reference Committee No. 5 as a whole, as amended.

Mr Speaker, I would like to thank the members of the Committee: William M. Renda, MD, Louisville; Frank K. Sewell, Jr, MD, Henderson; Ronald E. Waldrige, MD, Shelbyville; and Gary R. Wallace, MD, Lexington, for their time spent in listening to testimony and for their opinions and assistance in the preparation of this Committee report. I would also like to thank our secretary, Beth Thomas.

**Respectfully submitted,  
REFERENCE COMMITTEE NO. 5**

**Frank H. Catron, MD, Corbin, Chairman  
William M. Renda, MD, Louisville  
Ronald E. Waldrige, MD, Shelbyville  
Frank K. Sewell, Jr, MD, Henderson  
Gary R. Wallace, MD, Lexington**



*Editorial Note: Unless otherwise noted, the Reference Committee action on each Report and Resolution was accepted as printed. Any opposing action taken is stated in discussion following the item.*

## REPORT OF REFERENCE COMMITTEE NO. 6

**John W. Collins, MD, Lexington, Chairman**

- 34. Report of the Judicial Council
- 35. Report of the Rural Kentucky Medical Scholarship Fund
- 36. Report of the Physician-Attorney Liaison Committee
- 37. Report of the Membership Committee
- 38. Report of the Young Physicians Steering Committee
- 39. Report of the Medical Student Section
- 40. Report of the Resident Physicians Section
- 41. Report of the Ephraim McDowell Cambus-Kenneth Foundation, Inc
  - Resolution U — Hepatitis B Immunizations for Medical Students  
(KMA Resident Physicians Section)
  - Resolution W — Ethical Guidelines for Medical Consultants  
(Jefferson County Medical Society)
  - Resolution BB — Personal Listening Devices  
(Calloway County Medical Society)
  - Resolution EE — Commendation of the AMA  
(KMA Board of Trustees)

### ITEMS FOR CONSENT

Reference Committee No. 6 reviewed the following items and recommends they be filed, by consent of the House, without discussion:

- 34. Report of the Judicial Council — filed
- 38. Report of the Young Physicians Steering Committee — filed
- 39. Report of the Medical Student Section — filed
- 40. Report of the Resident Physicians Section — filed

Mr. Speaker, Reference Committee No. 6 recommends adoption of the Consent Calendar as a whole.

### Report of the Judicial Council

The Judicial Council met a number of times this year and continues to act as arbiter on behalf of the Association. Numerous patient complaints were received. Some were resolved and will be covered in this report; others remain subject to investigation. In addition, the Council was involved in some policy issues which will also be reported.

Patient complaints ranged from simple miscommunication between patients and physicians to actual questionable

physician practice. In one instance a patient complaint was received to the effect that a family member was not seen often enough in a nursing home and when taken to the hospital from the nursing home. On investigation, it was learned that the patient had been in the personal care category, but subsequently was referred to skilled care. It was suggested to the physician that he be more alert to changes in the category of care his nursing home patients received, and that "on call" protocols for nursing home patients be revised.

Two complaints were received which were routinely referred to the peer review mechanism for resolution.

Two separate patient complaints involved one physician who was contacted and initially failed to respond. Subsequently, responses from the physician developed into an impasse between the physician and both patients. However, because of some unknown and questionable practices, the matter was referred to the Board of Medical Licensure.

In another case, a woman was concerned that a physician did not admit her mother to the hospital when she presented in the emergency room with a very high blood pressure reading. Upon investigation, the Council determined that the patient was advised she should be admitted to the hospital that evening, but she specifically declined. She did agree to see her personal physician the following morning. The Council was advised that her blood pressure did respond favorably to medication given in the emergency room, and under those circumstances, she was released to go home as she requested. This case did present a dilemma physicians frequently face with uncooperative patients in regard to their medical treatment, and the physician was cautioned to fully document such problems in the medical records should they occur.

A physician complained about a relationship between the physician and a proprietary company furnishing services to a hospital on a contract basis. This complaint included the fact that another physician and a nonphysician working for the same company were writing orders and otherwise becoming involved in the treatment of the initial physician's patients. The hospital involved was contacted and asked to become active in the aspect of a physician and a nonphysician interacting in another physician's care of patients, and the matter was further referred to the Board of Medical Licensure.

In keeping with guidelines developed by the Council governing KMA membership status following disciplinary action by the Board of Medical Licensure, a physician was expelled from the Association for conviction of a felony. This same situation necessitated that the Association report this incident to the National Practitioner Data Bank.

The Council became involved in an issue concerning medical records and their release to the media by the coroner's office. The media reported on a patient's medical treatments after the patient's death, and there was concern that

this violated confidentiality. Legal counsel reviewed the statutes relating to coroners' duties and learned that medical records discovered during legal proceedings are open to the public. In this situation, there was an inquest to determine wrongful cause of death. Therefore, the records became accessible to the public. From this situation, the Judicial Council is investigating the feasibility of seeking a statutory change to the law relating to coroners.

Again this year the Council noted that while many patient complaints have validity, a general problem continues to be a lack of rapport between patients and physicians or, at best, inadequate communication. As physicians continue to have to conduct their medical activities in the context of increasing regulations and other bureaucratic demands, it is imperative that we not lose sight of the art of medicine and the necessity for its human side.

The Council would like to acknowledge with gratitude the many years of service of James C. "Cam" Cantrill, MD, who has served this body intermittently for 18 years.

As Chairman, I would like to thank council members, and particularly the Trustees, who were so helpful in conducting investigations. The Council invites comments and input from the entire membership and appreciates the support of the membership for its work.

**Will W. Ward, MD**  
**Chairman**

## **Report of Young Physicians Steering Committee**

The Young Physicians Steering Committee held two meetings this year to discuss ways to identify and address issues of interest to young physicians and increase young physicians' involvement in organized medicine.

In 1987, the AMA Young Physicians Section was formed to provide young physicians with a direct voice in policy decision making in all levels of organized medicine to ensure that such policies appropriately reflect the unique perspectives of young physicians. The section was formed to establish an ongoing presence for young physicians throughout all levels of organized medicine to foster awareness of the unique needs and concerns of young physicians and to ensure continuing opportunities to address such needs and concerns. It was hoped that the section would strengthen the broad based support of organized medicine by young physicians to increase membership levels, accomplishing this by encouraging state medical societies to develop either sections, committees, and/or study groups.

A Young Physicians Steering Committee was appointed to accomplish the goals outlined by the AMA-YPS by identifying those young physicians throughout the state interested in being appointed to positions of participation and leadership through committees and other activities of the Association.

Two seminars have been planned since the formation of the KMA Young Physicians Steering Committee to provide young physicians the opportunity to get together and discuss their concerns and issues that specifically apply to them. While the seminar held in April 1989 was well received, a second seminar, planned for April 1990, had to be cancelled due to low registration.

Although there was initial frustration over the lack of response to the seminars, it was noted that it is sometimes difficult for young physicians who are just beginning their careers to get away for a day or two to attend meetings. Other states report similar frustrations in their efforts to build interest among young physicians and agree that building involvement in medical organizations among this age group takes some time.

KMA has sent a Delegate and Alternate Delegate to the AMA-YPS meetings since 1989, and the Steering Committee felt that it was important to continue having representation from Kentucky at the AMA level.

Special ribbons have been ordered to identify young physicians attending the KMA Annual Meeting this fall, and a luncheon meeting for young physicians and their spouses will be held on Tuesday, October 1, at the Hyatt Regency Lexington.

The Committee is investigating the feasibility of surveying young physicians to identify issues that they feel are most important in Kentucky today. We also hope to learn of young physicians who are interested in serving on KMA committees.

The Committee appreciates the continuing support of the KMA Board of Trustees and officers of the Association.

**J. Gregory Cooper, MD**  
**Chairman**

## **Report of the Medical Student Section**

The Medical Student Section of the Kentucky Medical Association has been active and productive this year at all levels of organized medicine. Total student membership to the KMA is now at 690 members, representing over 82% of Kentucky medical students.

Both the UL and UK MSS chapters received Outreach Program Awards at the 1990 AMA Interim Meeting in Orlando for recruiting 204 AMA student members. Over 30 students represented Kentucky at the Interim and Annual Meetings of the AMA-MSS. Kentucky students appointed to national committees included Darin Harden, Rules, and Joel Shanklin, Reference Committee. The Section was also represented by Christa-Marie Singleton, Joel Shanklin, and Judy Linger at the AMA National Leadership Conference in February in Miami.

Judy Linger, MD, a recent UK graduate, ended two very successful years on the AMA-MSS Governing Council at the



1991 Annual Meeting. This past year she served as Chairperson of the Council and we deeply appreciate all the enthusiasm, time, and effort she put forth and the goals she accomplished. While Judy will be missed, we are happy to report that a UL student, Christa-Marie Singleton, will be taking a spot on the Governing Council after a victorious campaign in Chicago in June. Christa-Marie has been active on all levels of the MSS, including serving as Chairperson of the Long-Range Planning and Development Committee as well as Chairperson of a Reference Committee.

The UL KMA-MSS was actively involved in the Third Annual Health Care Classic 5K run/walk in April, which raised over \$2,000 for the John H. Morgan Center for the Homeless, an Outreach Program of the Jefferson County Medical Society. In addition, a "mentor" program was established and will be put into effect this year. This program pairs students with physicians in the community to serve as "mentors" during their four years of medical school.

The UK Chapter held an educational forum with the faculty and others to emphasize the need for adequate student education on and provisions for vaccination for Hepatitis B. Attendance at chapter meetings at UK averaged 100 students.

Both chapters conducted letter-writing campaigns to Kentucky's Congressmen urging support of HR 1482 and S 102 in regard to the student loan deferment issue. New officers were elected at both schools in the spring and are currently in the process of recruiting the incoming freshmen for AMA membership.

At the state level, the KMA-MSS Governing Council continues to meet quarterly in order to address issues facing medicine and the future activities of the Section. Officers for the 1991-92 year include Kela Lyons, President; Phil Budzenski, Chairperson; and Matt Shotwell, Secretary-Treasurer. Five students from each medical school serve on the state Governing Council and there are approximately 30 students from the two schools currently serving on KMA committees.

We would like to thank KMA for its continued support of the Medical Student Section and for its willingness to accept medical students as colleagues in a common goal. It is the desire of the Section to continue to be an active, contributing force in organized medicine.

**Kela J. Lyons  
President**

## Report of the Resident Physicians Section

Since the KMA Resident Physicians Section's beginning in 1984, it has been successful in fulfilling its mission to encourage physicians who are in postgraduate training in Kentucky to become involved in organized medicine. As evidence of

this success, the Section is proud of the following accomplishments:

1. Resident membership in the Association has experienced tremendous growth during these seven years, an almost 150% increase.
2. Currently, residents serve on almost every KMA committee and have been represented by voting delegates at all AMA and KMA meetings.
3. Policy proposed by the KMA-RPS has been adopted at every session of the KMA House of Delegates since the Section was established.

To continue this tradition, we have set a number of new goals for the Section this year and have reported them to the residents through the spring issue of the KMA-RPS newsletter.

One of our goals is to build membership, particularly at the University of Kentucky where less than 10% of the housestaff belong. Even though In-Training membership in KMA is currently at an all-time high, we still only represent approximately one-third of all Kentucky housestaff physicians. To accomplish our goal of at least 50% participation, we want to increase our communication with residents through programs and mailings such as the newsletter and to work on transitional programs with the medical students.

Along these lines, it was decided to hold, for the first time, a joint session with KMA's Medical Student Section. The 1991 KMA MSS/RPS meeting will be held on October 3 and will feature an outstanding program. Speaking on the issue of resident work hours will be Ward Griffen, MD, Executive Director of the American Board of Surgery, and former Chairman of Surgery at the University of Kentucky. Sharon Swan, Policy Analyst for the AMA-MSS, is also scheduled to speak on national legislative issues of importance to students and residents, ie, student loan deferment.

Another goal is to strengthen the function of the Governing Council by incorporating formal presentations at Council meetings. The Council, which is composed of representatives from each of the four training programs in Kentucky, met three times last year to discuss issues of concern to residents, elect its 1991 officers, review activities of the AMA-RPS, and plan the 1991 Annual Meeting. At its meeting on August 6, the Council was privileged to hear a report by Don Chasteen, KMA Director of Public Relations, on KMA's legislative agenda for the 1992 Kentucky General Assembly. We feel presentations such as this will better equip representatives with information that can be disseminated to residents in their respective programs. Topics for future presentations include trends in liability insurance and PRO matters.

The Council continues to have excellent representation at the KMA and AMA meetings. We were pleased that KMA-RPS Delegate, Laura Spalding Moore, MD, served on a 1990 Reference Committee to the House of Delegates and that a number of residents spoke on behalf of the three RPS Resolutions adopted by the House. The Resolutions, which dealt with local seat belt laws, water jet ski safety, and encour-

agement of breastfeeding, are being implemented by the appropriate KMA committees. Our goal for the Section is to not only continue to submit Resolutions at the state level, but to propose policy to the AMA-RPS House which meets twice a year.

Currently, the KMA-RPS sends one delegate to represent the Section at these national meetings. My goal is to secure additional outside funding to increase representation and we are pleased to report and gratefully acknowledge that additional funding was made available by the University of Louisville School of Medicine for Kentucky, for the first time, to have two delegates to the AMA-RPS Annual Meeting held in June in Chicago. W. Hal Skinner, MD, a fellow at the University of Kentucky, and David Butler, MD, a second-year resident at the University of Louisville, represented the Section at this meeting which dealt with such topics as mandatory HIV testing of health care workers; international health; resident work hours; graduate medical education reform legislation; and public health issues, such as crack babies and implantable estrogen.

Having been involved in the KMA-RPS since 1987 and having attended a number of KMA and AMA meetings, I feel strongly that residents need to get involved in organized medicine now. With the changes going on in the health arena today, we need to be equipped with more than academic and clinical experiences and to contribute to the decisions and policies that will affect us throughout our medical careers.

I join with the other members of the Governing Council in expressing gratitude to the House of the Delegates, the Board of Trustees, and to individual KMA members for giving Kentucky residents the opportunity through the KMA-RPS to have a voice and to be involved.

**Vaughn W. Payne, MD**  
**President**

## **END OF CONSENT CALENDAR ITEMS**

### **Report of Rural Kentucky Medical Scholarship Fund, Inc**

The Rural Kentucky Medical Scholarship Fund, Inc, (RKMSF) attempts to meet the medical needs of the rural population by alleviating the maldistribution of physicians. RKMSF currently administers two worthwhile programs in its efforts to meet this goal.

The first program provides low interest loans to medical students. Any loan recipient who practices primary care medicine in a county in critical need of physicians will be forgiven one loan for each full year of practice in the approved county. Any recipient practicing in a designated rural county

facing a primary care physician shortage which is less than critical must repay his/her loans at a discounted interest rate (currently 4.5%). Interest does not begin to accrue until the physician begins practicing.

For the school term 1991-92, the RKMSF made scholarship loans to 11 new applicants in the amount of \$10,000 each at 4.5% interest, and 15 loans to prior student recipients. A total of \$260,000 was expended in scholarship loans for 1991-92 as compared to \$190,000 in 1990-91.

There are currently 60 medical students/residents who have received loans from the RKMSF. The loans are granted for an eight year period. Two recipients are entering residency programs in 1991 — one in family practice and one in pediatrics. Eight recipients are currently enrolled in residency programs, and five recipients are entering practice in 1991. The remaining 45 recipients are currently in medical school.

There were eight recipients who received forgiveness for loans in 1990-91, and six recipients completed their financial and/or practice obligations in 1990-91.

The second program administered by RKMSF is the Establish Practice Grant Program (EPGP). The EPGP currently provides money to practicing physicians to assist in paying prior educational loans. For each year a physician in the EPGP practices in a critical county, he/she will be granted \$10,000 to be used toward an educational debt, with a maximum of \$40,000 granted per physician.

Four physicians are currently participating in the EPGP. The Program's participating physicians have all completed their first year of practice in a critical county in the state. Upon completion of a year of practice, each physician received a grant of \$10,000 to help defray his/her educational debt. The physicians are practicing in the counties of Adair, Knott, Menifee, and Russell.

The RKMSF has two main sources of income: interest accrued on the scholarship notes which are paid back or bought out and interest on investments. The average maturity of RKMSF investments is just over three years, with an average yield of 8.6%.

The Kentucky Medical Association continues to provide its support which greatly contributes to the success of the Fund. The RKMSF, while operated through the KMA, is a separate, nonprofit corporation, having its own Officers and Board of Directors. This report is furnished as an informational item.

**Donald R. Stephens, MD**  
**President**

### **Recommendations, Reference Committee 6:**

Reference Committee No. 6 reviewed the Report of the Rural Kentucky Medical Scholarship Fund and commends the President, Don Stephens, MD, and his Board for an excellent



report on the workings of the Fund. The Committee heard further testimony from Doctor Stephens and recommends that KMA members promote availability of the scholarship program and the Establish Practice Grant Program to students and residents.

Reference Committee No. 6 recommends that the Report of the Rural Kentucky Medical Scholarship Fund be filed.

## Report of Physician-Attorney Liaison Committee

The 1990 House of Delegates referred Resolution F to the Physician-Attorney Liaison Committee. The Resolution urged KMA to work with the Kentucky Bar Association (KBA) to develop a model living will and health surrogate document. In addition, the Resolution asked that KMA distribute the document at cost to physicians and encourage physician offices to have the documents available for patients.

We have met with the Chairman of the Kentucky Bar Association in an attempt to define parameters and to develop some type of outline to begin development of a joint document. However, the US Supreme Court decision rendered in the Nancy Cruzan case further confused the matter.

Many patients who favor living wills also want the option of having nutritional and hydrational support withheld or withdrawn as the Cruzan case seems to allow if an individual clearly expresses his or her preference in this regard. Although most authorities think Kentucky law precludes such directions under the 1990 legislative version, many authorities question whether this is true after Cruzan — especially where the Kentucky living will bill specifically states that the law is not intended to impair or supersede any common law or statutory right that an adult has to effect the withholding or withdrawal of medical care.

In the living will declaration sample is a statement regarding administration, medication, or treatment deemed necessary to alleviate pain or for nutrition and hydration. Although House Bill 113 specifies that life-prolonging treatment shall not include the administration of medicine or any procedures deemed necessary to alleviate pain for nutrition or hydration, there are extensive measures that may be used to deliver medication and to deliver nutrition and hydration. A patient with a certifiably terminal condition may not wish to have a central venous catheter placed for nutrition and may not wish to have a gastrostomy tube placed simply to prolong dying. Of course, we don't know whether it is possible to consider this with the present law, but it is hoped that such options may be written into an eventual KMA proposal and still be within the law.

A patient with a terminal condition whose pain is controlled but who becomes unable to swallow might rationally elect not to have operative procedures done to continue nutrition and hydration, if the law permits.

At the present time the "Probate and Trust Law" section of KBA, one of the 17 voluntary sections or committees formed by the Kentucky Supreme Court, is looking into this same matter and is expected to present a report at the annual KBA meeting, June 4-8, 1991. We hope that prior to the KMA Annual Meeting we can meet and begin the process based on this report. However, we are also participating with the Catholic Bishops Conference staff, Kentucky Hospital Association, Kentucky Nursing Home groups (KAHCF), nurses, and others in drafting amendments to the present law to meet US Supreme Court objections. We hope that a proper document, one which we can all agree on, can be drafted, presented to the 1992 Kentucky General Assembly, and have a chance for passage.

Bruce Lucas, MD, Director of the University of Kentucky Kidney Transplant Program, President of Kentucky Organ Donor Affiliates (KODA), and Chairman of the United Network for Organ Sharing (UNOS) Education Committee, noted that it is highly desirable to include personal desires regarding organ and tissue donation in any document dealing with living will provisions and health care surrogate instructions. We will place this matter on the agenda of the next meeting.

We point out that shortly after the 1990 Kentucky General Assembly, KMA printed with the "Communicator" a copy of the living will and the health surrogate document as included in the legislation. Copies of these documents are available from KMA upon request. We receive numerous requests and all are filled. Other groups providing documents include the Office of the Attorney General and the Legislative Research Commission. In addition, we understand several hospitals have documents available along with detailed information on the law.

The Committee's major responsibility is resolving complaints between the two honored professions. During the 1990-91 year, we are pleased to report that no formal complaints were received. We continue printing the Interprofessional code in the *Journal* on a biennial basis and provide copies to anyone upon request. It is apparent that both professions are aware of the code and generally understand its provisions.

We thank the House of Delegates for the opportunity to serve and look forward to fulfilling the objectives of Resolution F in the coming year.

**Lynn L. Ogden, MD**  
**Chairman**

## Recommendations, Reference Committee 6:

Reference Committee No. 6 next considered the Report of the Physician-Attorney Liaison Committee. The 1990 House of Delegates referred Resolution F (1990) to this Committee calling for KMA to work with the Kentucky Bar Association to

develop a model Living Will and Health Surrogate document. The Reference Committee noted that there is still ongoing evaluation of Resolution F because of the US Supreme Court decision in the Nancy Cruzan case and individual state laws. Reference Committee No. 6 would like to commend Lynn Ogden, MD, and his Committee for their work on this difficult issue.

Reference Committee No. 6 recommends that the Report of the Physician-Attorney Liaison Committee be filed.

## Report of the Membership Committee

Under the direction of the Membership Committee, a comprehensive plan for the recruitment and retention of practicing physicians, residents, and medical students in Kentucky has been undertaken this year.

We are pleased to report that membership continues to grow, again reaching an all-time high in 1990, with 5,601 KMA members. Recruitment efforts for 1990 resulted in 461 new members (242 Active, 209 In-Training, 10 Associate). Fortunately, this increase helped to offset the loss of 221 Active members due to death, relocation out of state, retirement, licensure action, and nonrenewal.

Although at year-end 1990 we showed a net gain of 67 Active members over 1989 figures, we actually fell behind in our market share from 77% of all potential members in 1989 to 76% in 1990. Current figures for 1991 stand at 74%.

The chart below lists current membership by Trustee District (ranked by membership percentage) noting the net gain/loss in the number of Active members during 1991 compared to the actual number of new Active members (including those pending approval) in each District.

District	6/91	Net Gain/Loss	# New Mbrs.
2	89%	+13	22
5	86%	+51	106
7	83%	+ 1	7
1	81%	- 5	11
3	81%	+ 2	8
8	76%	+10	27
12	72%	- 1	9
9	71%	+ 3	5
15	71%	- 6	7
4	70%	+ 1	15
13	65%	- 1	10
10	60%	+ 1	24
6	58%	-14	5
11	49%	+ 2	5
14	49%	+ 4	13
State Totals	74%	+61	274

In addition to factors already mentioned, ie, death, relocation, retirement, and nonrenewal, other losses in Active members this year include a number of physicians who requested dues exemption because of activation in the military services during Operation Desert Storm. KMA was pleased to join with the American Medical Association and a number of county medical societies in the state in waiving 1991 dues for physicians requesting an exemption.

Because of its concern in trying to maintain and increase the level of membership in the state, the Committee conducted a demographic study of all nonmembers and presented an annual report of 1990 membership to the KMA Board of Trustees in December. Factors considered in the study were age, specialty, and educational background.

The largest percentage of nonmembers (46%) are under the age of 40, many of whom are in the beginning years of practice. Another 32% are between the ages of 40 and 50. Half of all nonmembers are in a primary care specialty, with the highest number, 303 or 23%, in family practice. In fact, almost half of all nonmembers in the 2nd, 3rd, and 7th Trustee districts are family physicians.

In reviewing medical school background, it is interesting to note that 21% of the nonmembers are International Medical Graduates (IMGs) and 40% graduated from Kentucky schools (263 from the University of Louisville and 230 from the University of Kentucky).

### Recruitment and Retention Activities

Based on this study, a number of the Trustees undertook a personal campaign in their individual Districts to contact all nonmembers. The Committee wishes to thank Doctors John McClellan (2nd), Joseph Kutz (5th), Mark Pelstring (8th), Kelly Moss (9th), Charles Watson (13th), and Paul Smith (15th) for their help in recruitment in their areas.

Actually, membership activities for 1991 began just prior to last year's Annual Meeting and included two peer-to-peer campaigns and 14 separate statewide and targeted mailings, totaling over 6,200 individual contacts. A major part of the recruitment plan involves routine contact of physicians new to the state or just starting practice. In 1990, these efforts yielded a high response, as 184 joined out of 350 individual contacts for a 52% response. To date, we have gained 135 new members from these efforts in 1991.

The KMA membership videotape, which was developed in 1988 and proved to be a very successful recruitment tool, has been revised and will be used extensively for recruitment of new physicians in the coming year. The Committee acknowledges the contribution of Shawn Jones, MD, Louisville, for his participation in the edited version. We are also proud to report that the videotape has received widespread interest and was used as a pattern for a similar video produced by the Canadian Medical Association and one that is being created for the Medical Society of the State of New York.

We continue to rely on the efforts of individual county



medical societies in undertaking recruitment activities and commend the Fayette County, Jefferson County, and Northern Kentucky medical societies for a number of society programs to enhance membership in their areas. Other counties to be recognized for their increases this year include Daviess and Hardin, each with 11 new members, Hopkins with 7, and Henderson, McCracken, and Warren, each with 6 new members. The Committee continues to study and to be concerned about the number of counties in Kentucky with no organized medical society, noting that average membership in counties in this group is 51%, compared to 75% in counties with an organized society.

Retention continues to be a major function of the membership program and this year has received increased emphasis. Subsequent to the initial billing of members in late October, six separate mailings have been sent to encourage renewal. Although our annual nonrenewal phonathon was not held this year, we appreciate those Trustees and county society secretaries who were involved in personal follow-up to physicians who had not renewed by April 1.

## *Students and Residents*

Recruitment of students and residents continues to be an important aspect of our membership plan. Growth, not only in the number of members, but in the strength of the individual student and resident sections is an encouragement that organized medicine will have a strong future. Student leaders at both Kentucky medical schools were recognized at the AMA Interim Meeting for their outstanding recruitment this year, as over 200 new students joined for 1991. Currently, 81% of all Kentucky medical students belong to KMA.

In-Training membership has increased somewhat during 1991, but remains at one-third of all residents. A large number of new residents continue to join during the Housestaff Orientations and we are grateful to Andrew Pulito, MD, and Robert Goodin, MD, for their respective presentations at the University of Kentucky on June 25 and University of Louisville on June 28.

## *AMA Membership*

Several KMA members were active this year in outreach programs for the AMA and were recognized at the 1991 Annual Meeting held in June. We commend the following KMA Delegates and Alternate to the AMA for their successful recruitment efforts: Harold Bushey, MD; Robert Goodin, MD; and Donald Swikert, MD.

A national membership campaign, "MD (Member Driven) 2000," is being undertaken by the AMA with a goal to have half of all physicians in the US as AMA members by the year 2000. Through a national communications program as well as improving services and benefits to members, the AMA hopes to overcome a severe decline in market share which currently stands at 41%. The Membership Committee

will coordinate its efforts in the coming year to work with the AMA in meeting this goal.

## *Member Services*

Building on the success of previous years, KMA once again cosponsored with other county medical societies a number of workshops designed to help physicians and their office staffs increase their knowledge of practice management. Areas covered during the past year included Medicare updates, improving productivity, starting a practice, and a series of five separate sessions for medical office managers dealing with personnel, reimbursement, scheduling, etc.

Another KMA benefit, the group Workers' Compensation plan, resulted in a 15% return in insurance premiums to members participating in the program. The total amount returned for the KMA group amounted to over \$14,000.

The Committee welcomes input from the membership on potential member services and benefits for our review.

The 1990 House of Delegates referred the issue of Life membership qualification to KMA for further study and the Membership Committee was directed to discuss concerns of physicians who had retired, but had not met the age qualifications set forth in the Bylaws for the Life category. Upon further study, it has been determined that there is a mechanism in the KMA Bylaws whereby any retired physician, regardless of age, can maintain KMA dues-exempt, active membership upon approval of the Board of Trustees.

As has been our custom in this annual report, the membership status as of June 30, 1991, follows:

<b>Membership Category</b>	<b># as of 6/30/91</b>	<b># as of 12/31/90</b>
Active	3,690	3,723
In-Training	269	257
Total Dues-Paying	4,171	4,244
Total KMA All Categories	5,394	5,601

On behalf of the Membership Committee, we urge your participation and involvement in membership development. As reported by officers and other committees, the upcoming 1992 General Assembly promises to be one of our most challenging yet. By encouraging your colleagues to join their county society, KMA, and AMA, medicine's voice will be a much more viable instrument in dealing with the many issues facing medicine today.

**Harold D. Haller, Sr, MD**  
**Chairman**

## **Recommendations, Reference Committee 6:**

Reference Committee No. 6 reviewed the Report of the Membership Committee and heard its Chairman, Harold Haller, MD, testify that membership development is a responsibility of all members; he encourages all of us to make personal

contacts. It was noted that membership figures as of the 1991 Annual Meeting have surpassed year-end 1990 and increases in the In-Training and Medical Student categories are encouraging. Reference Committee No. 6 would like to thank Doctor Haller and his Committee for the amount of work and effort they have put into the Membership Committee.

Reference Committee No. 6 recommends that the Report of the Membership Committee be filed.

## **Report of the Ephraim McDowell Cambus-Kenneth Foundation, Inc.**

The Ephraim McDowell Cambus-Kenneth Foundation, incorporated on May 26, 1988, as a not-for-profit Kentucky corporation, exists exclusively for "charitable and educational purposes in promoting an appreciation of history through the acquisition, restoration, and preservation of buildings and properties having special historic significance. . . ."

The Foundation was formed by the Kentucky Medical Association for the purpose of accepting from Mr Joe A. Wallace and Mrs Cecil Dulin Wallace upon their deaths the 550-acre Cambus-Kenneth Farm located in Danville. This Farm was at one time owned by the pioneer physician, Ephraim McDowell, MD, served as his summer home, and was the site of his death. In addition, the assets of the former McDowell Memorial fund, including the McDowell House and Apothecary Shop, also in Danville, were conveyed by KMA to this Foundation.

The Corporation's Board of Directors met in April of this year with Mr and Mrs Wallace and David W. Kinnaird, MD, immediate past chairman of the McDowell House Managers Committee, being guests at the meeting. The first item of business was the election of the Foundation's corporate officers to include Preston P. Nunnelley, MD, President; G. Russell Shearer, MD, Vice-President; and William P. VonderHaar, MD, Secretary-Treasurer. Appointed as Executive Committee members of the Foundation Board were Doctor Nunnelley, Doctor Shearer, and Cecil D. Martin, MD.

In addition to the Foundation's Executive Committee, the McDowell House Managers Committee now operates under the auspices of the Foundation to supervise the maintenance and operation of the McDowell House and Apothecary Shop. A report of the financial status of the McDowell House was presented to the Board. Finances seemed to be in good order, with donations by "Friends of the McDowell House" totaling \$11,605 for 1990 with an additional \$8,270 contributed by the "Friends" from January to June 1991. The endowment fund value is in the range of \$190,000 to \$200,000. A report was also given on repairs made to the McDowell House during the year. In addition, changes in membership of the McDowell House Managers Committee were also approved. The Committee continues to meet on a

quarterly basis, and two members of the Committee are elected to serve with the Chairman as members of the Ephraim McDowell Cambus-Kenneth Foundation.

During the April meeting of the Foundation Board, a Planning Committee was appointed to establish goals for the present and future use of the Cambus-Kenneth Farm. Dr Kinnaird was asked to serve as Chairman with S. Randolph Scheen, MD, and G. Russell Shearer, MD, also appointed. As Chairman of the Planning Committee, Dr Kinnaird was also appointed as an ex-officio member of the Foundation Board.

Mr and Mrs Wallace have graciously agreed that during their lifetimes, any activity could begin which would fit into their vision of the Farm and that would fit the guidelines of the Foundation. It was agreed that goals for the present and future legacy of the Farm should be considered. A project of this nature will require funding which the Foundation Board feels should come from sources other than monies from the McDowell House endowment since the present endowment funds were given specifically for preservation, operation, and maintenance of the McDowell House and Apothecary Shop.

An excellent slide presentation of the Cambus-Kenneth Farm has been developed by Dr Kinnaird, to include the home, surrounding buildings, the countryside, and the Farm's location within the state. It was agreed by the Foundation Board that this would be an excellent tool to present this project to medical groups to make them aware of the possible opportunities the Farm offers. It is hoped that with appropriate funding, the Planning Committee will be in a position to secure assistance from someone knowledgeable about soliciting grants and other finances which could be used to eventually develop the Farm for charitable and educational purposes.

The Foundation Board is pleased to report that the Kentucky Medical Insurance Company, under the direction of Carl L. Wedekind, Jr, has made a generous contribution of \$1,000 to the Planning Committee for its work, and we are grateful to KMIC, its board, and Mr Wedekind for this support.

**Preston P. Nunnelley, MD  
Chairman**

### **Recommendations, Reference Committee 6:**

Reference Committee No. 6 next considered the Report of the Ephraim McDowell Cambus-Kenneth Foundation, Inc, and noted that the Foundation is an outstanding historical resource for KMA. The Reference Committee also noted that with this resource comes certain obligations and recommends that KMA members support the Foundation to the best of their abilities. Reference Committee No. 6 would like to thank Preston Nunnelley, MD, and his Foundation Board for their work toward preserving this part of Kentucky's medical history.



Reference Committee No. 6 recommends that the Report of the Ephraim McDowell Cambus-Kenneth Foundation be filed.

## **Resolution U**

### **Hepatitis B Immunizations for Medical Students KMA Resident Physicians Section**

WHEREAS, hepatitis B infection (HBV) is the major infectious occupational hazard to health care workers, and

WHEREAS, medical students, even in their first year, may begin contact with patients' blood and body fluids, and

WHEREAS, the HBV infection is preventable through vaccination prior to exposure to patients' blood, now therefore be it

RESOLVED, that KMA strongly urge the University of Kentucky College of Medicine and the University of Louisville School of Medicine to give prompt and serious consideration to the development and implementation of an effective educational program to address the increased risk to students of contracting hepatitis B, and be it further

RESOLVED, that KMA strongly urge the state medical schools to adopt mechanisms of implementing a program for hepatitis B vaccination for students prior to their clinical training.

#### **Recommendations, Reference Committee 6:**

Reference Committee No. 6 considered Resolution U, Hepatitis B Immunizations for Medical Students, submitted by the KMA Resident Physicians Section, and heard testimony from its author, Baretta Casey, MD, in regard to early implementation of Hepatitis B immunization and education for medical students. Reference Committee No. 6 recommends that Resolution U be adopted.

(Ralph D. Caldrony, MD, Delegate from Fayette County, was recognized, who offered the suggestion that the medical schools consider some financial underpinning for those students who can claim legitimate financial hardship, as the vaccinations are not being offered free of charge at this time, which may deter some students from acquiring them.)

## **Resolution W**

### **Ethical Guidelines for Medical Consultants Jefferson County Medical Society**

WHEREAS, there is an increasing demand on physicians to be involved as administrators, business consultants, expert witnesses, and in other capacities which do not involve direct patient care; and

WHEREAS, the exercise of medical judgement is key to many decisions as to the scope of coverage afforded by health insurance policies; and

WHEREAS, a physician acting as a medical consultant to a health insurance company should have a duty to be trained or to have experience in the field of specialty in which he or she is asked to express coverage opinions and decisions; and

WHEREAS, if not possessed of such training or experience, a physician acting as a medical consultant to a health insurance company should have a duty to independently research medical literature or to consult specialists in the field before expressing a coverage decision contrary to the advice of an attending/treating physician; and

WHEREAS, a consulting physician's use of the title "MD" in correspondence advising a patient-insured or an attending/treating physician of coverage decisions implies that the physician's professional judgement has been brought to bear, and should impose ethical obligations on the physician which are different from duties imposed on the company's lay employees charged only with enforcement of administrative policy; now therefore be it

RESOLVED, that the Kentucky Medical Association develop, or actively encourage and support the Kentucky Board of Medical Licensure's development, of ethical guidelines for physicians serving as administrators, consultants, witnesses, and in other business or judicial capacities which do not involve direct patient care.

#### **Recommendations, Reference Committee 6:**

Reference Committee No. 6 next reviewed Resolution W, Ethical Guidelines for Medical Consultants, submitted by the Jefferson County Medical Society and notes the timeliness of this Resolution. Reference Committee No. 6 recommends that Resolution W be adopted.

Cecil D. Martin, MD, Chairman of the Board of Trustees, was recognized, who made a motion, on behalf of the Board, that Resolution W be submitted to the American Medical Association for consideration by the AMA House of Delegates. The motion was seconded from the floor and carried.

## **Resolution BB**

### **Personal Listening Devices Calloway County Medical Society**

WHEREAS, accidents are a leading cause of death among American citizens, and accidents are the leading cause of death among teenagers and young adults; and

WHEREAS, many of the accidents involve motor vehicles and pedestrians, joggers, and bicyclers, and the use of headphones and other personal listening devices by these individuals impairs and limits their awareness of their potential roadway peril; and

WHEREAS, organized medicine is taking a leading role in promoting safety regulations; that is, seatbelt laws, child

restraint laws, etc; and

WHEREAS, more people are enjoying the health benefits of jogging, bicycling, etc, on public streets; however, the use of headphones and personal listening devices places these persons at some increased physical risk; now therefore be it

RESOLVED, that the Kentucky Medical Association support legislation to establish restriction of the use of personal listening devices by joggers and bicyclers using public thoroughfares.

**Recommendations, Reference Committee 6:**

Reference Committee No. 6 considered Resolution BB, Personal Listening Devices, submitted by the Calloway County Medical Society, and heard testimony from Dan Miller, MD, of the Calloway County Medical Society, in regard to a recent young person's death attributable to the use of a personal listening device while cycling. The Committee noted lively discussion from the audience with the general consensus that this may be a problem on a wide scale, but that more information and data are needed.

Reference Committee No. 6 recommends that Resolution BB be referred to the KMA Board of Trustees for further study and evaluation of the need for public education and/or legislation.

**Resolution EE**

**Commendation of the AMA  
Board of Trustees**

WHEREAS, the Health Care Finance Administration proposed reductions in Medicare RBRVS reimbursement of 16% which were unacceptable to all physicians; and

WHEREAS, the American Medical Association immediately made this issue a top priority and assumed the leadership role in coordinating the efforts of county, state, and national medical specialty societies to overturn this proposal; and

WHEREAS, the synergistic effort of the federation was successful, demonstrating the effectiveness of organized medicine; and

WHEREAS, members of Congress and the national news media have indicated that the American Medical Association was the central unifying force which created pressure upon HCFA to honor Congress' original intent; now therefore be it

RESOLVED, that the Kentucky Medical Association does hereby commend the American Medical Association for its leadership in the fight to restore full funding to the physician component of the RBRVS Medicare payment system; and be it further

RESOLVED, that this House of Delegates does hereby commend those individual county medical societies and physicians who wrote HCFA voicing their outrage over its

attempt to ignore the intent of Congress; and be it further

RESOLVED, that this House of Delegates calls on all Kentucky physicians, who are not now members of the American Medical Association, to recognize the many benefits of the Federation's actions and to support these and future efforts by becoming members of the American Medical Association, KMA, and their county medical society.

**Recommendations, Reference Committee 6:**

Reference Committee No. 6 reviewed Resolution EE, Commendation of the AMA, submitted by the KMA Board of trustees, and supports the Board in its recognition and commendation of the AMA for its leadership in the fight to restore funding for physicians under RBRVS. Reference Committee No. 6 therefore recommends the adoption of Resolution EE.

Mr Speaker, Reference Committee No. 6 recommends the adoption of the report of Reference Committee No. 6 as a whole.

Mr Speaker, I would like to thank the members of the Reference Committee for their help with the issues discussed and in the formulation of this report. Members of the Committee were: Peter C. Campbell, MD, Louisville; Nick G. Dedman, MD, Harrodsburg; Bob M. DeWeese, MD, Louisville; and Matthew Shotwell, University of Kentucky medical student, Lexington. I would also like to thank Diane Maxey for her help in preparing this report.

**Respectfully submitted,  
REFERENCE COMMITTEE NO. 6**

**John W. Collins, MD, Lexington, Chairman**  
**Peter C. Campbell, MD, Louisville**  
**Nick G. Dedman, MD, Harrodsburg**  
**Bob M. DeWeese, MD, Louisville**  
**Matthew Shotwell, Lexington (MSS)**

**Election of Officers**

Ralph D. Caldrony, MD, Acting Chairman of the Nominating Committee, presented the slate of nominees for offices as follows:

President-Elect	William B. Monnig, MD Edgewood
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Dr Monnig was elected by acclamation, and escorted to the podium by Past Presidents Bob M. DeWeese, MD, and Wally O. Montgomery, MD.

Vice President	Ardis D. Hoven, MD Lexington Larry J. Wilson, MD Louisville
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Following a vote taken by ballot, it was announced that Dr Hoven had been elected Vice President.



Dr. Caldrony then presented names of the nominees for the AMA Delegation (term — January 1, 1992 to December 31, 1993) and each was elected by acclamation:

Delegates to the AMA	Donald C. Barton, MD Corbin Harold L. Bushey, MD Barbourville
Alternate Delegates to the AMA	Donald J. Swikert, MD Florence J. Gregory Cooper, MD Cynthiana (nominated from the floor)

Dr Caldrony then submitted the following nominations for the offices of Trustees and Alternate Trustees on behalf of the Trustee District nominating committees, and each was elected by acclamation:

2nd District Trustee	John W. McClellan, MD Henderson
2nd District Alternate	Christopher R. McCoy, MD Owensboro
7th District Trustee	Ronald E. Walldridge, MD Shelbyville

7th District Alternate

9th District Trustee

9th District Altenate

10th District Trustee

10th District Alternate

13th District Trustee

13th District Alternate

J. Michael Watts, MD

Cynthiana

Don R. Stephens, MD

Cynthiana

Robert L. McKenney, MD

Falmouth

Russell L. Travis, MD

Lexington

Gary R. Wallace, MD

Lexington

Charles T. Watson, MD

Ashland

Bruce M. Stapleton, MD

Ashland

## **Election of 1992 Nominating Committee**

The following physicians were elected by the House of Delegates to serve as the 1992 KMA Nominating Committee:

John D. Noonan, MD, Paducah, Chairman

J. William Comer, MD, Louisville

Kenneth R. Hauswald, MD, Ashland

Dennis B. Kelly, MD, Lexington

G. Irene Minor, MD, Berea

Speaker Clark adjourned the 1991 Session of the KMA House of Delegates at 9:10 PM.

# 1991 CONSTITUTION AND BYLAWS OF THE KENTUCKY MEDICAL ASSOCIATION

## CONSTITUTION

Article I.	Name of the Association
Article II.	Purpose of the Association
Article III.	Component Societies
Article IV.	Composition and Meetings of the Association
Article V.	Officers
Article VI.	House of Delegates
Article VII.	Districts, Sections and District Societies
Article VIII.	Board of Trustees
Article IX.	Funds and Expenses
Article X.	Referendum
Article XI.	The Seal
Article XII.	Amendments
Article XIII.	Definitions

### Article I. Name of Association

The name and title of this organization shall be the Kentucky Medical Association.

### Article II. Purpose of the Association

The purpose of the Association shall be to federate and bring into compact organization the entire medical profession of the State of Kentucky and to unite with similar associations in other states to form the American Medical Association, with a view to the extension of medical knowledge; the advancement of medical science and charity; the evaluation of the standards of medical education; the enactment and enforcement of just medical laws; the promotion of friendly intercourse among physicians and the guarding and fostering of their material interests; the protection of the members thereof against unjust assaults upon their professional care, skill or integrity; and to the enlightenment and direction of public opinion in regard to the great problems of state medicine so that the profession shall become more capable and honorable within itself and more useful to the public in the prevention and cure of disease and in prolonging and adding comfort to life.

### Article III. Component Societies

Component societies shall consist of those medical societies which hold charters from this Association.

### Article IV. Composition and Meetings of the Association

The Association shall consist of the members of the component societies, but the House of Delegates shall have authority to adopt such bylaws regulating the admission and classification of members as it may deem advisable. The Association shall hold an Annual Meeting and such Special Meetings as may be called pursuant to the bylaws.

### Article V. Officers

**Section 1.** The officers of this Association shall be a President, a President-Elect, a Vice-President, a Secretary-Treasurer, a Speaker and Vice-Speaker of the House of Delegates, a Trustee and an Alternate Trustee from each district that may be established; and such other officers as may be provided for in the Bylaws.

**Section 2.** The eligibility, duties and terms of office of all officers of the Association shall be as prescribed in the Bylaws.

**Section 3.** All officers shall serve until their successors have been elected and installed.

**Section 4.** All officers shall be elected by the House of Delegates at its Regular Session and shall take office on the last day of the Annual Meeting.

### Article VI. House of Delegates

**Section 1.** The House of Delegates shall be the legislative body of the Association and shall have power, by a two-thirds vote of all the delegates present at that session, to adopt bylaws to carry out the provisions of this Constitution and to provide for the government of the Association in any other manner not inconsistent with this Constitution. It shall meet in Regular Session, annually during the Annual Meeting of the Association, and may

be called into Special Session under such conditions as may be prescribed in the bylaws.

**Section 2.** Delegates shall be members of and elected by component county societies in such a manner as may be provided in the Bylaws. Officers of the Association, Delegates and Alternate Delegates of the American Medical Association and five immediate Past Presidents shall be the ex-officio members of the House of Delegates and entitled to vote. All other Past Presidents and Vice-Presidents and Past Chairmen of the Board of Trustees shall be ex-officio members of the House. They shall have the right to speak and debate on the floor of the House but shall not have the right to make a motion, introduce business or an amendment, or vote.

**Section 3.** The House of Delegates shall elect a Speaker and a Vice-Speaker, one of whom shall preside during the meetings of the House of Delegates. The presiding officer shall not be entitled to a vote except in the event of a tie.

**Section 4.** The House of Delegates shall be the final judge as to the qualification of its members.

### Article VII. Districts, Sections and District Societies

The House of Delegates shall divide the state into Districts composed of one or more counties, for administrative purposes. It may also provide for a division of the scientific work of the Association into appropriate Sections, and for the organization of such District Societies, composed exclusively of members of component societies, as will promote the best interests of the profession.

### Article VIII. Board of Trustees

The House of Delegates shall make provision in the bylaws for a Board of Trustees composed of one Trustee from each District and such of the other officers of the Association as the House may deem appropriate, which shall be charged with the general direction of the Association's affairs during the interim between meetings of the House. The House may delegate such powers to the Board of Trustees as are not specifically required by this Constitution to be exercised by the House, and may limit the Board's powers to such extent as it may determine to be necessary or desirable, provided, however, that in no event shall the Board of Trustees have power to commit the Association to any course of action which is contrary to or at variance with any policy established by the House of Delegates.

### Article IX. Funds and Expenses

The House of Delegates shall provide funds for meeting the expenses of the Association by such methods and from such sources as it may select. Funds may be appropriated by the House of Delegates to defray the expenses of the annual session, for publications, and for such other purposes as will promote the welfare of the Association and the profession.

### Article X. Referendum

The membership of the Association, by written petition signed by not less than 10% of the active membership, may obtain a referendum on any question pending before the House of Delegates. The Secretary-Treasurer, upon the presentation of such a petition to him shall cause the question to be submitted to the active membership by mail, and if a majority of the active members shall signify its approval or disapproval of a certain policy or course of action with respect to the question thus submitted, the will of the majority shall determine the question and shall be binding upon the House of Delegates and the Association upon certification of the result of the vote by the Secretary-Treasurer to the President and Board of Trustees.

### Article XI. The Seal

The Association shall have a common Seal with power to break, change or renew the same at pleasure.

### Article XII. Amendments

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the delegates registered at the Regular Session, provided



that such amendment shall have been presented in open meeting at the previous regular session, and that it shall have been sent officially to each component county society at least two months before the session at which final action is to be taken.

### Article XIII. Definitions

Whenever used in this Constitution, the Articles of Incorporation or the Bylaws—

(a) "County society," "component county society," or "component medical society" means "component society."

(b) "Annual Meeting" means the annual three-day meeting of the Association.

(c) "Scientific Sessions" mean those sessions during the Annual Meeting at which scientific subjects are programmed and discussed.

(d) "Regular Session" means the regular session of the House of Delegates which is held during the Annual Meeting.

(e) "Special Session" means a special, called meeting or session of the House of Delegates.

### BYLAWS

Chapter I.	Membership
Chapter II.	Annual and Special Meetings of the Association
Chapter III.	The House of Delegates
Chapter IV.	Election of Officers
Chapter V.	Duties of Officers
Chapter VI.	Board of Trustees
Chapter VII.	Discipline-The Judicial Council
Chapter VIII.	Standing Committees and Councils
Chapter IX.	Assessments and Expenditures
Chapter X.	Rules of Conduct
Chapter XI.	Rules of Order
Chapter XII.	County Societies
Chapter XIII.	Amendments

### CHAPTER I. MEMBERSHIP

**Section 1.** Membership in this Association shall be coterminous with membership in a component county society. No physician shall be eligible for membership in this Association unless he is a member, in good standing of a component society, nor may he maintain membership in a component county society unless he is a member, in good standing of this Association.

When a physician who meets the qualifications hereinafter set forth, is certified to the Secretary-Treasurer as a member in good standing of a component society, properly classified as to type of membership, and when the dues pertaining to his membership classification have been received by the Secretary-Treasurer of the Association, the name of the member shall be included in the official roster of the Association and he shall be entitled to all the privileges of his class of membership. Provided, however, that members in good standing from other state societies may, if admitted to membership by a component society, be accepted by KMA for membership without paying dues for the remainder of the calendar year in which the transfer is made. Provided further, that the Board of Trustees shall have power, upon written application, approved annually by the county society of which the applicant is a member, to excuse any member from the payment of dues because of financial hardship. And provided further, that the Judicial Council, after a hearing, shall have power to condition membership in this Association upon the physician's agreement to limit the scope of his practice in any manner reasonably calculated to protect the public from the adverse effects of any demonstrated frailty or disability of said member.

**Section 2.** Membership in the Association shall be divided into nine classes, to wit: Active, Life, In-Training, Associate, Inactive, Student, Service, Honorary and Special.

(a) **Active Members.** The active membership of the Association shall consist of the active members of the various component medical societies. To be eligible for active membership in any component society, the applicant must be a physician who holds an unrestricted or limited license to practice medicine and surgery in this state, and who is of good moral, ethical and professional standing. Nothing contained herein shall prevent a component society from requiring new members to occupy provisional status for a reasonable time after their admittance to membership under any classification.

(b) **Life Members.** Component societies may elect as a life member any doctor of medicine or osteopathy who has served his profession with distinction and who has reached the age of 70 and has retired from active practice. Further, any member who has 25 years of continuous membership in a state medical society affiliated with the American Medical Association, who has reached the age of 65 and is fully retired, also may be elected as a life member. However, any member who had qualified as a life member at the time of the adoption of this amendment, September 26, 1990, shall continue to qualify as a life member. Life members shall have the right to vote and be entitled to the benefits of Chapter VI, Section 8, of these

Bylaws, but shall not pay dues. They shall receive *The Journal* and other publications of the Association.

(c) **Resident Physicians Section.** Doctors of medicine or osteopathy who have complied with all pertinent regulations of the Kentucky Board of Medical Licensure and who are serving in AMA approved training programs in Kentucky shall be eligible for membership in the Resident Physicians Section of the Kentucky Medical Association. The Resident Physicians Section shall be governed by its own Constitution and Bylaws, which shall not be in conflict with the Constitution, Bylaws and Board policies of the parent Kentucky Medical Association. Should any questions arise regarding the existence of a conflict, the KMA Board of Trustees shall be the final arbiter of such questions. In-Training members in good standing shall have the right to vote and receive all publications of the Association. In-Training members shall not be counted in determining the number of delegates to which their county society is entitled in the House of Delegates. The Resident Physicians Section will be represented in the KMA House of Delegates by one voting representative elected by the Governing Council of the Resident Physicians Section.

(d) **Associate Members.** The associate membership of the Association shall consist of the associate members of the various component medical societies. To be eligible for associate membership in any component society, the applicant must qualify under one or more of the following groups:

(1) Medical officers of the United States Army, Navy, Air Force, Veterans Administration, Public Health Service, or other federal governmental service while on duty in the State, but shall not be deemed to include physicians employed on a full-time basis by the Veterans Administration.

(2) Dentists may be invited to become Associate members.

(3) Physicians residing and/or practicing in communities bordering Kentucky who are active members of their home state and county society and who wish to become members of KMA on an other than active basis may become Associate Members.

Associate members shall not have the right to vote nor to hold office, but shall receive *The Journal* and other publications of the Association.

(e) **Inactive Members.** The inactive membership of the Association shall consist of the inactive members of the various component county societies. Any doctor of medicine licensed to practice medicine in Kentucky who is not engaged in the practice of medicine but who is otherwise eligible for active membership in the Association may be admitted to inactive membership by any component county society. Inactive members shall not have the right to vote nor hold office, but shall receive *The Journal* and other publications of the Association.

(f) **Student Members.** Any student in an accredited medical school in Kentucky or any resident of Kentucky who is a student in an accredited medical school in the United States shall be eligible for membership in the Medical Student Section of the Kentucky Medical Association. This Medical Student Section shall be governed by its own Constitution and Bylaws, which Constitution and Bylaws shall not be in conflict with the Constitution, Bylaws and Board policies of the parent Kentucky Medical Association. Should any questions arise regarding the existence of a conflict, the KMA Board of Trustees shall be the final arbiter of such questions. Membership shall be coincident with the academic enrollment of the student. Student members may not hold office in the State Association, but may be voting members of any State Association committee to which they are appointed. Student members may, however, hold office within the Student Section in accord with the provisions of that Section's Constitution and Bylaws. The Student Section will be represented in the KMA House of Delegates through one voting representative, a student member of the Kentucky Medical Association elected by the Student Section membership attending the University of Kentucky College of Medicine, and one voting representative, a student member of the Kentucky Medical Association elected by the Student Section membership attending the University of Louisville School of Medicine.

(g) **Service Members.** Members of the Association in good standing who enter military service and are ineligible for Associate membership shall be classified as service members. Service Members shall not be required to pay dues. If a member in good standing enters service prior to April 1 and has paid his dues for that year, he shall receive all publications and other benefits applicable to his class of membership in the Association and shall owe no further dues until January 1 following his release. If a member in good standing enters service prior to April 1 without paying his dues for that year, he shall receive publications and other benefits but shall owe the dues applicable to his class of membership immediately following his release from active duty. Members whose dues have not been received by April 1 are not in good standing.

(h) **Honorary Members.** Any physician possessed of scientific attainments who is a member of a constituent state medical association and who has participated in the program of the scientific session and who is not



a citizen of Kentucky may by unanimous vote of the House of Delegates be elected to honorary membership. Honorary members shall be entitled to the privileges of the floor in all scientific sessions.

(i) **Special Members.** Component societies may invite pharmacists, funeral directors, or other professional persons to become special members. Special members shall have no rights or obligations under these Bylaws, but may be accorded the privilege of attending and participating in the scientific meetings of the society, provided, however, that a registration fee may be required of special members who desire to attend the Annual Meeting of the Association.

**Section 3. Hospital Medical Staff Section.** There shall be a special section for hospital medical staff physicians who already hold membership in KMA. The Hospital Medical Staff Section (HMSS) shall be governed by its own Constitution and Bylaws, which Constitution and Bylaws shall not be in conflict with the Constitution, Bylaws and Board policies of the parent Kentucky Medical Association. Should any questions arise regarding the existence of a conflict, the KMA Board of Trustees shall be the final arbiter of such questions. The Hospital Medical Staff Section shall elect a Delegate and Alternate Delegate to the KMA House of Delegates. The Delegate to the KMA House of Delegates, or his Alternate as the case may be, shall be a voting member of the House and may present resolutions on behalf of the HMSS.

**Section 4. Guests of Honor.** Any distinguished physician not a resident of this State may become a guest of honor during any Annual Meeting upon invitation of the Board of Trustees and shall be accorded the privilege of participating in all of the scientific work of that meeting.

**Section 5.** No person who is finally convicted of a felony subsequent to September 26, 1968, shall be eligible for membership in this Association unless and until, upon proper application to the Judicial Council, it is determined that he is morally and ethically qualified. Except as provided in Chapter VII, Section 4 of these Bylaws, no person who is under sentence of suspension or expulsion from any component society of this Association shall be entitled to any of the rights or benefits of membership of this Association.

## CHAPTER II. ANNUAL AND SPECIAL MEETINGS OF THE ASSOCIATION

**Section 1.** The Association shall hold its annual and special meetings at such times and places as may be determined by the House of Delegates.

**Section 2.** The Annual Meeting shall consist of one or more scientific sessions, at least two meetings of the House of Delegates, and such other gatherings as may be authorized by the Board of Trustees. Each scientific session shall be presided over by the President or in his absence or disability or at his request by the President-Elect or such officers as the Board of Trustees may direct. The entire time of the scientific sessions, as far as may be, shall be devoted to papers and discussions related to scientific medicine.

**Section 3.** The name of a physician upon the properly certified roster of members or list of delegates of a component society which has paid its annual assessment, shall be prima facie evidence of his right to register at any meeting of this Association.

**Section 4.** Each member in attendance at any meeting shall register indicating the component society of which he is a member. When his right to membership has been verified by reference to the roster of the society, he shall receive a badge which shall be evidence of his right to all privileges of membership at that meeting. No member or delegate shall take part in any of the proceedings of any meeting until he has complied with the provisions of this section.

## CHAPTER III. THE HOUSE OF DELEGATES

**Section 1.** The House of Delegates shall meet in Regular Session at the time and place of the Annual Meeting, and shall, insofar as is practicable, fix its hours of meeting so as to give delegates an opportunity to attend the scientific sessions and other proceedings. Provided, however, that if the business interests of the Association and profession require, the Speaker, with the consent of the Board of Trustees, may convene the Regular Session in advance of the Annual Meeting, and the House may remain in session after the final adjournment thereof.

**Section 2.** The House may be called into Special Session by the President with the approval of the Board of Trustees, and a special session shall be called by the President on the written request of fifty duly elected delegates of the Association. The purpose of all special sessions shall be stated in the call, and all business transacted at any such special session shall be germane to the stated purpose.

**Section 3.** When a special session is called, the Secretary-Treasurer shall mail a notice of the time, place, and purpose of such meeting to the last known address of each delegate at least ten days before such session.

**Section 4.** The Speaker shall, by virtue of his office, be responsible for making all arrangements for all sessions, regular or special, of the House.

**Section 5.** The members of the House of Delegates shall be elected by the various component societies in the manner prescribed in Chapter XII of these Bylaws.

**Section 6.** In the event a component society is not represented at any meeting of the House, the Speaker shall consult with any officer of the component society who is in attendance and, with the approval of the Credentials Committee, may appoint any active member of such component society who is in attendance, as its alternate delegate. If no officer of such society is present, the Speaker may make the appointment without consultation, but with the approval of the Credentials Committee. All such appointments shall also be subject to the approval of the House.

**Section 7.** Forty percent of the qualified delegates, as defined by Article VI of the constitution, shall constitute a quorum and all of the meetings of the House shall be open to the members of the Association. The House shall have the right to go into executive session whenever in its judgment such action is indicated; except that active members of the Association shall have the right to attend all executive sessions.

**Section 8.** Each resolution introduced into the House shall be in writing and signed by the author and presented to the Secretary-Treasurer following its introduction. If the author presenting the resolution presents it as an individual member of the Kentucky Medical Association, the resolution shall be signed by him. If the author be a group of members or component society, the resolution shall be signed by the authorized spokesman for that group. Immediately after the resolution has been introduced, it shall be referred to the proper Reference Committee before action thereon is taken.

**Section 9.** No resolution shall be introduced in the first meeting of the House of Delegates by any member or group of members other than the Board of Trustees unless a copy thereof was furnished to the Headquarters Office at least seven days prior to its introduction. The only exception to this shall be that a resolution which has been signed by ten or more members of the House of Delegates and of which there are sufficient printed copies to distribute to each member of the House of Delegates may be received for consideration by an affirmative vote of three-fourths of the members present and voting. No new business shall be introduced in the last meeting of the House without unanimous consent, except when presented by the Board of Trustees. All new business so presented shall require the affirmative vote of three-fourths of those delegates present and voting, for adoption.

**Section 10.** The House shall give diligent attention to and foster the scientific work and spirit of the Association, and shall constantly study and strive to make each Annual Meeting a stepping stone to further ones of higher interest.

**Section 11.** It shall consider and advise as to the material interest of the profession, and of the public in those important matters wherein the public is dependent upon the profession, and shall use its influence to secure and enforce all proper medical and public health legislation, and to diffuse information in relation thereto.

**Section 12.** It shall make careful inquiry into the condition of the profession of each county in the State, and shall have authority to adopt such methods as may be deemed most efficient for building up and increasing the interest in such county societies as already exist and for organizing the profession in counties where societies do not exist. It shall especially and systematically endeavor to promote friendly intercourse between physicians of the same locality and shall continue these efforts until every physician in every county of the State who will agree to abide by the constitution, bylaws and other rules and regulations of the Association and the appropriate component society, has been brought under medical society influence.

**Section 13.** It shall encourage postgraduate work in medical centers as well as home study and research and shall endeavor to have the results of the same utilized and intelligently discussed in the county societies.

**Section 14.** It shall elect representatives to the House of Delegates of the American Medical Association in accordance with the Constitution and Bylaws of that body.

**Section 15.** It shall, upon application, provide and issue charters to county societies organized in conformity with the Constitution and Bylaws of this Association.

**Section 16.** The state shall be divided into the following districts:

No. 1 — Ballard, Calloway, Carlisle, Fulton, Graves, Hickman, Livingston, McCracken, and Marshall.

No. 2 — Daviess, Hancock, Henderson, McLean, Ohio, Union, and Webster.

No. 3 — Caldwell, Christian, Crittenden, Hopkins, Lyon, Muhlenberg, Todd, and Trigg.

No. 4 — Breckinridge, Bullitt, Grayson, Green, Hardin, Hart, Larue, Marion, Meade, Nelson, Taylor, and Washington.

No. 5 — Jefferson.

No. 6 — Adair, Allen, Barren, Butler, Cumberland, Edmonson, Logan, Metcalf, Monroe, Simpson, and Warren.

No. 7 — Anderson, Carroll, Franklin, Gallatin, Grant, Henry, Oldham, Owen, Shelby, Spencer, and Trimble.

No. 8 — Boone, Campbell, and Kenton.

No. 9 — Bath, Bourbon, Bracken, Fleming, Harrison, Mason, Nicholas, Pendleton, Scott, and Robertson.

No. 10 — Fayette, Jessamine, and Woodford.



No. 11 — Clark, Estill, Jackson, Lee, Madison, Menifee, Montgomery, Owsley, Powell, and Wolfe.

No. 12 — Boyle, Casey, Clinton, Garrard, Lincoln, McCreary, Mercer, Pulaski, Rockcastle, Russell, and Wayne.

No. 13 — Boyd, Carter, Elliott, Greenup, Lawrence, Lewis, Morgan, and Rowan.

No. 14 — Breathitt, Floyd, Johnson, Knott, Letcher, Magoffin, Martin, Perry, and Pike.

No. 15 — Bell, Clay, Harlan, Knox, Laurel, Leslie, and Whitley.

District meetings may be held as desired, and District Medical Associations may be organized as desired, according to the districts outlined above.

**Section 17.** It shall have authority to appoint committees for special purposes from among members of the Association who are not members of the House of Delegates and such committees may report to the House of Delegates in person, and may participate in the debate thereon.

**Section 18.** It shall approve all memorials and resolutions issued in the name of the Association before the same shall become effective, except as provided in Chapter VI, Section 4, and except for the selection of the recipient of the Kentucky Medical Association Award (Outstanding Layman) and Distinguished Service Award (Outstanding Physician), which selections shall be made by the KMA Awards Committee.

**Section 19.** A digest of proceedings of the House of Delegates shall be published and distributed to the membership annually.

#### **CHAPTER IV. ELECTION OF OFFICERS AND DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION**

**Section 1.** The President-Elect and the Vice President shall be elected from the state at large for a term of one year, the President-Elect succeeding to the presidency at the expiration of his term as President-Elect. A majority vote of those attending and voting shall be required for the election of the President-Elect and the Vice President and on any ballot where a majority is not obtained, the candidate with the least votes shall be dropped and further balloting held until such time as one candidate receives a majority of the votes cast. Delegates to the AMA and their alternates shall be elected from the state at large for terms of two years with the provision that no more than one delegate and no more than one alternate delegate shall be elected from one component society. The Speaker of the House of Delegates, the Vice-Speaker and the Secretary-Treasurer shall be elected for terms of three years. Trustees and their Alternates shall be elected for terms of three years and Trustees shall be limited to serving for not more than two consecutive full terms. The terms of the Trustees and their Alternates shall coincide and be so arranged that one-third of the terms expire each year, insofar as possible, provided, however, that nothing contained herein shall preclude an Alternate Trustee from serving two full terms as a Trustee. No member shall be eligible for the office of President, President-Elect, Vice-President, Secretary-Treasurer, Speaker or Vice-Speaker of the House of Delegates, Trustee or Alternate Trustee who has not been an active member of the Association for at least three years.

**Section 2.** During the last meeting of the regular session of the House of Delegates, the Speaker of the House of Delegates shall submit to the members of the House of Delegates a list of ten names from which, by ballot, the House of Delegates shall select five members to serve as the Nominating Committee for the next year. The five names receiving the most votes shall form the Committee, and the person receiving the most votes shall be Chairman. In the event that the Chairman so elected is unable or unwilling to serve, or in the event of a tie, the Committee shall elect one of its members as Chairman. The Committee shall meet at such time and place as determined by the Committee Chairman or the Board of Trustees, and shall schedule an open meeting immediately after the close of the first meeting of the House at each Annual Meeting. This open meeting shall be held in the meeting place of the House of Delegates, shall receive broad publicity, and those who have business to discuss with the committee shall have a hearing. The Nominating Committee shall verify the eligibility and willingness to serve of each candidate nominated. The Committee shall accept and post for information all eligible and willing candidates proposed for offices elected from the state at large. Before noon of the day following the opening meeting, the committee shall post on a bulletin board near the entrance to the hall in which the Annual Meeting is being held, its nomination, or nominations, for each office to be filled, and shall formally present said nomination, or nominations, to the House at the time of the election. Additional nominations may be made from the floor by submitting the nominations without discussion or comment. Vacancies occurring on the Nominating Committee by virtue of death, resignation, or disability, shall be filled by appointment of the Speaker.

**Section 3.** The election of officers and delegates to the AMA and their alternates shall be held at the second meeting of the regular session of the House of Delegates.

**Section 4.** All elections shall be by secret ballot, and a majority of the votes cast shall be necessary to elect, provided, however, that when there

are more than two nominees, the nominee receiving the least number of votes on the first ballot shall be dropped and the balloting shall continue in like manner until an election occurs.

**Section 5.** Any member may make known his availability for any office within the Association. However, it would be regarded as unseemly for any member to actively campaign for his own election.

**Section 6.** The Delegates representing the counties in each District form the Nominating Committee for the purpose of nominating a Trustee and an Alternate Trustee for the District concerned. This committee shall hold a well publicized meeting open to all active members of the District concerned who are in attendance at the Annual Meeting for the purpose of discussing the nomination of the Trustee and his Alternate to serve the District. Additional nominations may be made from the floor when the Nominating Committee makes its report to the House of Delegates.

#### **CHAPTER V. DUTIES OF OFFICERS OTHER THAN TRUSTEES AND ALTERNATES**

**Section 1.** Except as provided in Chapter II, Section 2 hereof, the President shall preside at all scientific sessions of the Association and shall appoint all committees not otherwise provided for. He shall deliver an annual address at such time as may be arranged and shall perform such duties as custom and parliamentary usage may require. He shall be the real head of the profession in the State during his term of office and so far as practicable, shall visit or cause to be visited on his behalf, the various sections of the State and assist the Trustees in building up the county societies and in making their work more practical and useful. He shall be reimbursed for his reasonable and necessary travel expense incurred in the performance of his duties as President.

**Section 2.** The President-Elect shall assist the President in visitation of county and other meetings. He shall become president of the Association at the next Annual Meeting following his election as president-elect. In the event of his death or resignation, or if he becomes permanently disqualified or disabled, his successor shall be elected by the House of Delegates and shall be installed as President of the Association at its next regular session.

**Section 3.** The Vice President shall assist the President in the discharge of his duties, and shall perform such other duties as may be prescribed by the Board of Trustees. In the event of a vacancy in the office of the President, the Vice-President shall succeed to the office of the President.

**Section 4.** The President-Elect and the Vice-President, when acting for and in behalf of the President, may be reimbursed for their reasonable and necessary travel expenses incurred in the performance of their duties in such amounts as may be available out of the sum appropriated in the annual budget for traveling expenses.

**Section 5.** The Speaker of the House shall preside at all meetings of the House of Delegates. He shall appoint all committees of the House of Delegates with the approval of the House of Delegates. He shall be a non-voting member of said committees, and shall perform such other duties as custom and parliamentary usage may require.

**Section 6.** The Vice Speaker shall assume the duties of the Speaker in his absence and shall assist the Speaker in the performance of his duties. In the event of the death, disability, resignation, or removal of the Speaker, the Vice Speaker shall automatically become Speaker of the House of Delegates.

**Section 7.** The Secretary-Treasurer shall advise the Executive Vice President in all administrative matters of this Association and shall act as the corporate secretary insofar as the execution of official documents or institution of official actions are required. He shall perform such duties as are placed upon him by the Constitution and Bylaws, and as may be prescribed by the Board of Trustees. The Secretary-Treasurer shall demand and receive all funds due the Association, including bequests and donations. He shall, if so directed by the House of Delegates, sell or lease any real estate belonging to the Association and execute the necessary papers and shall, subject to such direction, have the care and management of the fiscal affairs of the Association. All vouchers of the Association shall be signed by the Executive Vice President or his designee and shall be countersigned by the Secretary-Treasurer of the Association. When one or more of the above-named officials are not readily available, four specifically designated representatives of the Executive Committee are authorized to countersign the vouchers, provided that in any event all vouchers of the Association shall bear a signature and a countersignature. The four members of the Executive Committee authorized to countersign vouchers shall be designated by the Board during their reorganizational meeting in September and, whenever possible should be easily accessible from the KMA Headquarters Office. All those authorized to countersign vouchers shall be required to give bond in an amount to be determined by the Board of Trustees. The Secretary-Treasurer shall report the operations of his office annually to the House of Delegates, via the Board of Trustees, and shall truly and accurately account for all funds belonging to the Association and coming into his hands during the year. His accounts shall be audited annually by a certified public accountant appointed by the Board of Trustees.



## CHAPTER VI. BOARD OF TRUSTEES

**Section 1.** The Board of Trustees shall be the executive body of the House of Delegates and between sessions of the House of Delegates shall exercise the powers conferred upon the House of Delegates by the Constitution and Bylaws. The Board of Trustees shall consist of the duly elected Trustees and the President, the President-Elect, the Vice-President, the immediate Past-President, the Speaker, and Vice-Speaker of the House of Delegates, the Secretary-Treasurer, and the Delegates and Alternate Delegates to the American Medical Association. The Executive Committee of the Board of Trustees shall consist of the President, the Vice-President, the President-Elect, the Secretary-Treasurer, the Chairman of the Board of Trustees, the Vice Chairman of the Board of Trustees, and two Trustees to be elected annually by the Board of Trustees. A majority of the full Board, and a majority of the full Executive Committee, to-wit, 5, shall constitute a quorum for the transaction of all business by either body. Between sessions of the Board, the Executive Committee shall exercise all the powers belonging to the Board except those powers specifically reserved by the Board to itself.

**Section 2.** The Board shall meet daily, or as required, during the Annual Meeting of the Association and at such other times as necessity may require, subject to the call of the Chairman or on petition of three Trustees. It shall meet on the last day of the Annual Meeting for reorganization and for the outlining of the work for the ensuing year. It shall, through its Chairman, make an annual report to the House of Delegates at such time as may be provided, which report shall include an audit of the accounts of the Secretary-Treasurer and other agents of this Association and which shall also specify the character and cost of all the publications of the Association during the year, and the amounts of all other property belonging to the Association, or under its control, with such suggestions as it may deem necessary. By accepting or rejecting this report, the House may approve or disapprove the action of the Board of Trustees in whole or in part, with respect to any matter reported upon therein. In the event of a vacancy in any office other than that of President, the Board may fill the same until the annual election.

**Section 3.** Each Trustee shall be organizer, peacemaker and censor for his district. He shall hold at least one district meeting each year for the exchange of views on problems relating to organized medicine and for post-graduate scientific study. The necessary traveling expenses incurred by a Trustee in the line of his duties herein imposed may be paid by the Secretary-Treasurer upon a proper itemized statement but this shall not be constituted to include his expenses in attending the Annual Meeting of the Association.

**Section 4.** The Board shall have the authority to communicate the views of the profession and of the Association in regard to health, sanitation, and other important matters, to the public and press.

**Section 5.** The *Journal of the Kentucky Medical Association* shall be the official organ of the Association and shall be published under the supervision of the Board. The Editor of the *Journal* shall be elected by the Board. All money received by the *Journal* or by any member of its staff on its behalf, shall be paid to the Secretary-Treasurer on the first of each month. The Board shall provide for and superintend the publication and distribution of all proceedings, transactions, and memoirs of the Association, and shall have authority to appoint such assistants to the Editor as it deems necessary.

**Section 6.** All commercial exhibits during the Annual Meeting shall be within the control and direction of the Board.

**Section 7.** In the event of the death, resignation, removal or disability of a Trustee, between sessions of the House of Delegates, the Alternate Trustee shall succeed to the office of Trustee. In the case of disability, the Alternate shall serve until the disability is removed or the Trustee's term expires, and in the absence of the Trustee, the Alternate Trustee shall vote in his place and stead.

**Section 8.** The Association, upon the request of any member in good standing who is a defendant in a professional liability suit, will provide such member with the consultative service of competent legal counsel selected by the Secretary-Treasurer acting under the general direction of the Executive Committee. In addition, the Association may, upon application to the Board outlining unusual circumstances justifying such action, provide such member with the services of an attorney selected by the Board to defend such suit through one court.

**Section 9.** The Board shall employ an Executive Vice President whose principal duty shall be to carry out and execute the policies established by the House of Delegates and the Board. His compensation shall be fixed by the Board. The Executive Vice President shall act as general administrative officer and business manager of the Association and shall perform all administrative duties necessary and proper to the general management of the Headquarters Office, except those duties which are specifically imposed by the Constitution and Bylaws upon the officers, committees, councils and other representatives of the Association. He shall refer to the various elected officials all administrative questions which are properly within their jurisdiction.

He shall attend the Annual Meeting, the meetings of the House of Delegates, the meetings of the Board, as many of the committee and council meetings as possible, and shall keep separately the records of their respective

proceedings. He shall, at all times, hold himself in readiness to advise and aid, so far as is possible and practicable, all officers, committees, and councils of the Association in the performance of their duties and in the furtherance of the purposes of the Association. He shall be allowed traveling expenses to the extent approved by the Board.

He shall be the custodian of the general papers and records of the Association (including those of the Secretary-Treasurer) and shall conduct the official correspondence of the Association. He shall notify all members of meetings, officers of their election, and committees and councils of their appointment and duties.

He shall account for and promptly turn over to the Secretary-Treasurer all funds of the Association which come into his hands. It shall be his duty to receive all bills against the Association, to investigate their fairness and correctness, to prepare vouchers covering the same, and to forward them to the Secretary-Treasurer for appropriate action. He shall keep an account with the component societies of the amounts of their assessments, collect the same, and promptly turn over the proceeds to the Secretary-Treasurer. He shall, within thirty days preceding each Annual Meeting, submit his financial books and records to a certified public accountant, approved by the Board, whose report shall be submitted to the House of Delegates.

He shall keep a record of all physicians in the State by counties, noting on each his status in relation to his county society, and upon request shall transmit a copy of this list to the American Medical Association.

He shall act as Managing Editor, or otherwise supervise the publication of *The Journal of the Kentucky Medical Association* and such other publications as may be authorized by the House of Delegates, under the guidance and direction of the Board.

He shall perform such additional duties as may be required by the House of Delegates, the Board, or the President, and shall employ such assistants as the Board may direct. He shall serve at the pleasure of the Board, and in the event of his death, resignation, or removal, the Board shall have the power to fill the vacancy. From time to time, or as directed by the Board, he shall make written reports to the Board and House of Delegates concerning his activities and those of the Headquarters Office.

## CHAPTER VII. DISCIPLINE — THE JUDICIAL COUNCIL

**Section 1.** There is hereby created a Judicial Council composed of the Secretary-Treasurer of the Association and four members to be elected by the House of Delegates for terms of four years each. One member shall be elected from each of the traditional eastern, western, and central districts, and one member from the state at large. Members of the first Judicial Council shall be elected for terms of one, two, three, and four years, respectively so that thereafter, one member will be elected each year. The Council shall annually elect a chairman.

To be eligible for membership on the Judicial Council, a nominee shall possess at least one of the following qualifications: (1) Have served one term as an officer, trustee, or a Delegate to the AMA or (2) Have served five years as a member of the House of Delegates.

It shall be the duty of the Board of Trustees to nominate at least one candidate for each vacancy on the Judicial Council, but additional nominations may be made from the floor. Vacancies which occur between Regular Sessions of the House of Delegates, shall be filled by the Board of Trustees. No member, other than the Secretary-Treasurer shall serve more than two consecutive terms.

**Section 2.** The Judicial Council shall be the Board of Censors of the Association. It shall be the final arbiter of all questions involving the right and standing of members, whether in relation to other members, to the component societies, or to this Association. All charges of breach of medical ethics brought before the House of Delegates shall be referred to the Judicial Council without discussion. A member who has been convicted of a felony or of any violation of the Medical Practice Act, or who violates any of the provisions of the constitution, bylaws, or any rule or regulation of this Association, or the Principles of Ethics of the American Medical Association shall be liable to censure, fine, suspension, or expulsion upon order of the Judicial Council. Provided, however, that if in addition to discipline by the Association, the Judicial Council shall be of the opinion that the offending member's license to practice medicine shall be revoked, it shall report this to the Board of Trustees as a recommendation that the Board refer the matter to the State Board of Medical Licensure for this purpose.

Suspension shall be for a specified period during which the member shall remain liable for the payment of dues but shall not be eligible to hold office, attend business meetings or otherwise participate in Associational activities at the county, district or state levels. Upon the expiration of the period of suspension, every suspended member shall be automatically restored to all of the rights and privileges of his class of membership unless the Judicial Council determines that his conduct during the period of suspension indicates that he is unworthy of such restoration, in which event his suspension may be extended or he may be expelled.

Upon the complaint of any member or aggrieved individual involved, the



Judicial Council may initiate disciplinary proceedings against any member, and may intervene in or supersede county, individual trustee, or district disciplinary proceedings, whenever in its sole judgment and opinion, a disciplinary matter is not being handled in an expeditious manner, and may render a decision therein. In all cases in which the Association, rather than a member or aggrieved individual, appears to be the real party in interest, the Judicial Council may refer the complaint to the Board of Trustees for a determination as to whether probable cause for disciplinary action exists. If the Board of Trustees resolves this question in the affirmative, it shall so charge the respondent, and a representative of the Board shall thereupon be responsible for presenting the evidence in support of such charge at any hearing held thereon.

In all proceedings of the Judicial Council, the due process requirements of reasonable notice and a full and fair hearing shall be observed. No recommended disciplinary decision of an individual trustee or any district grievance committee shall become effective unless and until approved by the Judicial Council.

**Section 3.** It shall consider all appeals from the recommended decisions of individual trustees and District Grievance Committees. In this case of appeals from the decisions of individual trustees, the Judicial Council may admit such oral or written evidence as in its judgment will best and most fairly present the facts, but all appeals from the recommended decisions of District Grievance Committees shall be considered on the record made before such committee. It shall be the duty of the Secretary to notify the parties with respect to its disposition of each case.

**Section 4.** The Judicial Council may hear appeals from the disciplinary orders of component societies. Provided, however, that such appeals shall be considered on the record made before the component societies.

**Section 5.** Efforts toward conciliation and compromise shall precede the hearing of all disciplinary cases, but the decision of the Judicial Council shall be final. A party aggrieved by the decision of the Judicial Council may seek an appeal to the Judicial Council of the American Medical Association in accordance with the jurisdiction, rules and regulations of that Association.

**Section 6.** Component societies are encouraged to create suitable disciplinary procedures which guarantee due process, and to dispose of all disciplinary problems which come to their attention. It is recognized, however, that it may not be feasible for some societies to do so, and the District Grievance Committees hereinafter created, are designed to meet the needs of county societies which are without a functioning grievance committee.

**Section 7.** The trustee of each district is hereby designated the chairman of his District Grievance Committee. The Judicial Council shall designate two additional trustees from districts adjoining that of the chairman, and the three trustees thus selected shall constitute the District Grievance Committee. All grievances which cannot be resolved by individual trustees, shall be referred to the local grievance committee or the district grievance committee for the district in which the respondent physician or county society resides.

**Section 8.** District Grievance Committees shall investigate every grievance coming to their attention, taking care that the physician complained of shall have ample opportunity to respond to the complaint. If, after careful investigation the complaint appears to be without merit, the committee shall so report to the Judicial Council, including sufficient facts in its report to enable Judicial Council to form its own conclusions.

If the District Grievance Committee's investigation indicates that the member may be a proper subject of disciplinary action, the committee shall, upon reasonable notice, hold a hearing at which the complainant and the respondent shall be entitled to be represented by counsel, to present the testimony of witnesses in his behalf, and to cross-examine witnesses against him. All testimony shall be under oath and shall be recorded by a competent reporter at the expense of the Association, but shall not be transcribed unless and until an appeal is taken as hereinafter provided.

When all of the testimony has been heard and all evidence received, the committee shall make written findings and recommendations which it shall transmit to the Judicial Council, furnishing copies thereof to the parties.

**Section 9.** Any party aggrieved by the findings or recommendations of the committee, may, within 30 days, appeal to the Judicial Council. Appeals shall be taken by filing with the Secretary-Treasurer a copy of the entire record made before the District Grievance Committee (including a transcript of the testimony, procured at the appellant's expense) together with a written statement of appeal pointing out in detail wherein the committee has erred, and directing the attention of the Judicial Council to those portions of the transcript upon which he relies, provided, however, that the Judicial Council may extend the time in which the transcript must be filed, upon request made within the initial thirty-day period.

**Section 10.** No report or opinion of the Judicial Council shall be considered the policy of the Association until approved by the House of Delegates. Any report or opinion of the Judicial Council submitted to the House of

Delegates may be accepted or rejected or referred back to the Judicial Council but not modified by the House of Delegates.

## **CHAPTER VIII. COMMITTEES AND COMMISSIONS**

**Section 1.** The Board of Trustees shall have authority from time to time to appoint, fix the duties of, and abolish such standing committees and commissions as it deems necessary or desirable to assist it in carrying on the Association's activities in the fields of business and scientific meetings, medical education and hospitals, legislation, medical services, communications and public service, and governmental medical services.

**Section 2.** The Executive Committee shall serve as the nominating committee for all standing committee and commission appointments, but the trustees may make additional nominations. When the Executive Committee sits as such nominating committee, the President-Elect shall serve as Chairman.

**Section 3.** The President, with the advice and consent of the Chairman of the Board of Trustees, may appoint temporary ad hoc committees to perform specified functions. All such committees shall expire at the end of the term of the President by whom appointed.

**Section 4.** No committee or commission shall have power or authority to fix or determine Associational policy or to commit the Association to any course of action, such powers being expressly reserved to the House of Delegates and the Board of Trustees.

## **CHAPTER IX. ASSESSMENTS AND EXPENDITURES**

**Section 1.** The annual dues for membership in this Association shall be as follows: (1) Active Member, \$400, (except (a) those physicians elected to KMA membership within six months of the completion of their residency, fellowship or fulfillment of government-obligated service shall pay only one-half of the full active member rate their first full year of membership; (b) those physicians in their second year of practice shall pay only three-fourths of the full active member rate for their second full year of membership; and (c) those physicians who have reached the age of 70 and work 20 hours or less per week shall pay only one-half of the full active member rate per year for their KMA membership); (2) Life Members, no dues; (3) Associate Members, \$75; (4) In-training Members, \$30, except that in-training members shall not be liable for dues during the first six months of their first postgraduate year in an approved residency program in Kentucky; (5) Inactive Members, \$80; (6) Students Members, no dues; (7) Service Members, no dues; (8) Special Members, no dues. The dues during the first year for any active member shall be prorated on a quarterly basis as determined by the date of his application. Dues fixed by these Bylaws shall constitute assessments against the component societies. Unless otherwise instructed by the Board of Trustees (which may institute centralized billing) the Secretary of each component society shall forward its assessments, together with its properly classified roster of all officers and members, list of delegates, and list of non-affiliated physicians of the county, to the Secretary-Treasurer of this Association as of the first day of January each year.

**Section 2.** Unless otherwise provided by the Board of Trustees pursuant to Section 1 hereof, any component society which fails to pay its assessments, or make the report as required, on or before the first day of April in each year, shall be held as suspended and none of its members or delegates shall be permitted to participate in any of the business or proceedings of the Association or of the House of Delegates until such requirements have been met.

**Section 3.** All motions and resolutions appropriating money shall specify a definite amount or so much thereof as may be necessary for the purpose, and must have prior approval of the Board of Trustees before they can become effective. No motion or resolution, the adoption of which would require a substantial expenditure of funds, shall be considered by the House of Delegates unless the funds have been budgeted or are provided by the motion or resolution.

## **CHAPTER X. RULES OF CONDUCT**

The principles set forth in the Principles of Ethics of the American Medical Association, together with the Constitution and Bylaws of the Association and all duly adopted resolutions of the House of Delegates, shall govern the conduct of members in their relation to each other and to the public.

## **CHAPTER XI. RULES OF ORDER**

The deliberations of this Association shall be governed by parliamentary usage as contained in the latest edition of Sturgis' Standard Code of Parliamentary Procedure, unless otherwise determined by a vote of its respective bodies.

## **CHAPTER XII. COUNTY SOCIETIES**

**Section 1.** Except as provided in Section 3 of this Chapter, all county medical societies in this State which have adopted principles of organization not in conflict with this Constitution and Bylaws shall, upon application to the House of Delegates, receive a charter from and become a component part of this Association.

The House of Delegates shall have authority to evoke the charter of any component society whose actions are in conflict with the letter or spirit



of the Constitution and Bylaws.

**Section 2.** As rapidly as can be done after the adoption of this Constitution and Bylaws, a medical society shall be organized in every county in the state in which no component society exists, and charters shall be issued thereto.

**Section 3.** Only one component society shall be chartered in any county. Membership in the component society thus created shall entitle the members thereof to all the rights and benefits of membership in the Kentucky Medical Association.

**Section 4.** In sparsely settled sections two or more component societies may join for scientific programs, the election of officers, and such other matters as they may deem advisable. The component societies thus combined shall not lose any of their privileges or representation. The active members of each component society shall annually elect at least a Secretary and a Delegate for the transaction of its business with the Association.

Two or more adjacent component societies may also combine into one multi-county component society by adopting resolutions to that effect at special meetings called for that purpose on at least ten days' notice. Copies of the resolution, certified as to their adoption by the Secretary of each society, shall be forwarded to the Headquarters Office. If approved by the Board of Trustees, the multi-county society shall thereupon be issued a charter, the consolidating county societies shall cease to exist and the multi-county society shall become a component society of this Association; provided, however, that the active members residing in each county comprising the multi-county society shall be entitled to elect a delegate or delegates to the House of Delegates, as if each such county constituted a component society within the meaning of Section 11 of this Chapter; and provided, further, that multi-county societies may elect, at large, one alternate delegate for each delegate to which it is entitled under this section and such alternate may serve in the absence of the delegate for whom he is the designated alternate.

A multi-county component society may be disaggregated so that an individual county society may regain independent status when a majority of the members in that county indicate their desire to reorganize. At that time the members from the withdrawing county shall forward a petition containing the signatures of a majority of the members in that county to be validated by KMA. The withdrawing county shall further forward a resolution to the KMA Headquarters Office to be submitted to the House of Delegates at its next regular meeting, requesting recognition as a county society and issuance of a charter, in accord with Chapter XII, Section I of the KMA Bylaws. Once this charter is issued, the new county society shall become a recognized entity at the beginning of the following KMA dues year and those counties remaining with the original multi-county unit may continue to function under their pre-existing charter.

**Section 5.** Each component society shall be the sole judge of the qualifications of its own members. All members of component societies shall be members of the Kentucky Medical Association and shall be classified in accordance with Chapter I, Section 2 of these Bylaws, provided, however, that no physician who is under suspension or who has been expelled shall thereafter, without reinstatement by the Board of Trustees be eligible for membership in any component society. Any physician who desires to become a member of the Kentucky Medical Association shall first apply to the component society in the county in which he resides, for membership therein. Except as hereinafter provided in Sections 6 and/or 8 of this chapter, no physician shall be an active member of a component society in any county other than the county in which he resides.

**Section 6.** Any physician who may feel aggrieved by the action of the component society of the county in which he resides, in refusing him membership, shall have the right to appeal to the Board of Trustees, which, upon a majority vote, may permit him to apply for membership in a component society in a county which is adjacent to the county in which he resides.

**Section 7.** When a member in good standing in a component society moves to another county in the State, his name, upon request, shall be transferred without cost to the roster of the component society into whose jurisdiction he moves, if he is admitted to membership therein.

**Section 8.** A physician whose residence is closer to the headquarters of an adjacent component society than it is to the headquarters of the component society of the county in which he resides, may, with the consent of the component society within whose jurisdiction he resides, hold membership in said adjacent component society.

**Section 9.** Each component society shall have general direction of the affairs of the profession in the county, and its influence shall be constantly exerted for bettering the scientific, moral and material conditions of every physician in the county. Systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it embraces every qualified physician in the county.

Upon reasonable notice and after a hearing, component societies may discipline their members by censure, fine, suspension or expulsion, for any breach of the Principles of Medical Ethics or any bylaw, rule or regulation lawfully adopted by such societies or this Association. At every hearing, the

accused shall be entitled to be represented by counsel and to cross-examine witnesses, and the society shall cause a stenographic record to be made of the entire proceedings. The stenographer's notes need not be transcribed unless and until requested by the respondent member.

Any physician aggrieved by the disciplinary action of a component society may, within ninety (90) days, appeal to the Judicial Council, whose decision shall be final. This appeal shall be in writing and shall point out in detail the errors committed by the county society. It shall be accompanied by a transcript of the proceedings before the county society, procured at appellant's expense, and the statement of appeal shall direct the attention of the Judicial Council to those portions of the transcript upon which he relies.

Any member who fails or refuses to comply with the lawful disciplinary orders of his component society shall, if such failure or refusal continues for more than thirty (30) days, be automatically suspended from membership, provided, however, that an appeal shall stay the suspension until a final decision is made by the Judicial Council.

The resignation of a member against whom disciplinary charges are pending or who is in default of the disciplinary judgment of his county society, a district grievance committee or the Board of Trustees shall not be accepted and no member who is suspended or expelled may be reinstated or readmitted unless and until he complies with all lawful orders of his component society and the Board of Trustees.

**Section 10.** Frequent meetings shall be encouraged and the most attractive programs arranged that are possible. Members shall be especially encouraged to do postgraduate and original research work, and to give the society the first benefit of such labors. Official positions and other references shall be unstintingly given to such members.

**Section 11.** At the time of the annual election of officers, each component society shall elect a delegate or delegates to represent it in the House of Delegates. The term of a delegate shall commence on the first day of the regular session of the House following his election, and shall end on the day before the first day of the next regular session, provided, however, that component societies may elect delegates for more than one term at any election. Each component society may elect one delegate for each 25 voting members in good standing, plus one delegate for one or more voting members in excess of multiples of 25, provided, however that each component society shall be entitled to at least one delegate regardless of the number of voting members it may have and that each multi-county society shall be entitled to the same number of delegates as its component societies would have had. The secretary of the society shall send a list of such delegates to the Secretary-Treasurer of this Association not later than 45 days before the next Annual Meeting. It shall be the obligation of a component society which elects delegates to serve more than one year, to provide the KMA Headquarters Office with a certified list of its delegates each year.

**Section 12.** The secretary of each component society shall keep a roster of its members and a list of nonaffiliated licensed physicians of the county, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this State, and such other information as may be deemed necessary. He shall furnish an official report containing such information upon blanks supplied him for the purpose, to the Secretary-Treasurer of the Association, on the first day of January of each year or as soon thereafter as possible, and at the same time the dues accruing from the annual assessment are sent in. In keeping such roster the secretary shall note any change in the personnel of the profession by death or by removal to or from the county, and in making his annual report he shall be certain to account for every physician who has lived in the county during the year.

## CHAPTER XIII. AMENDMENTS

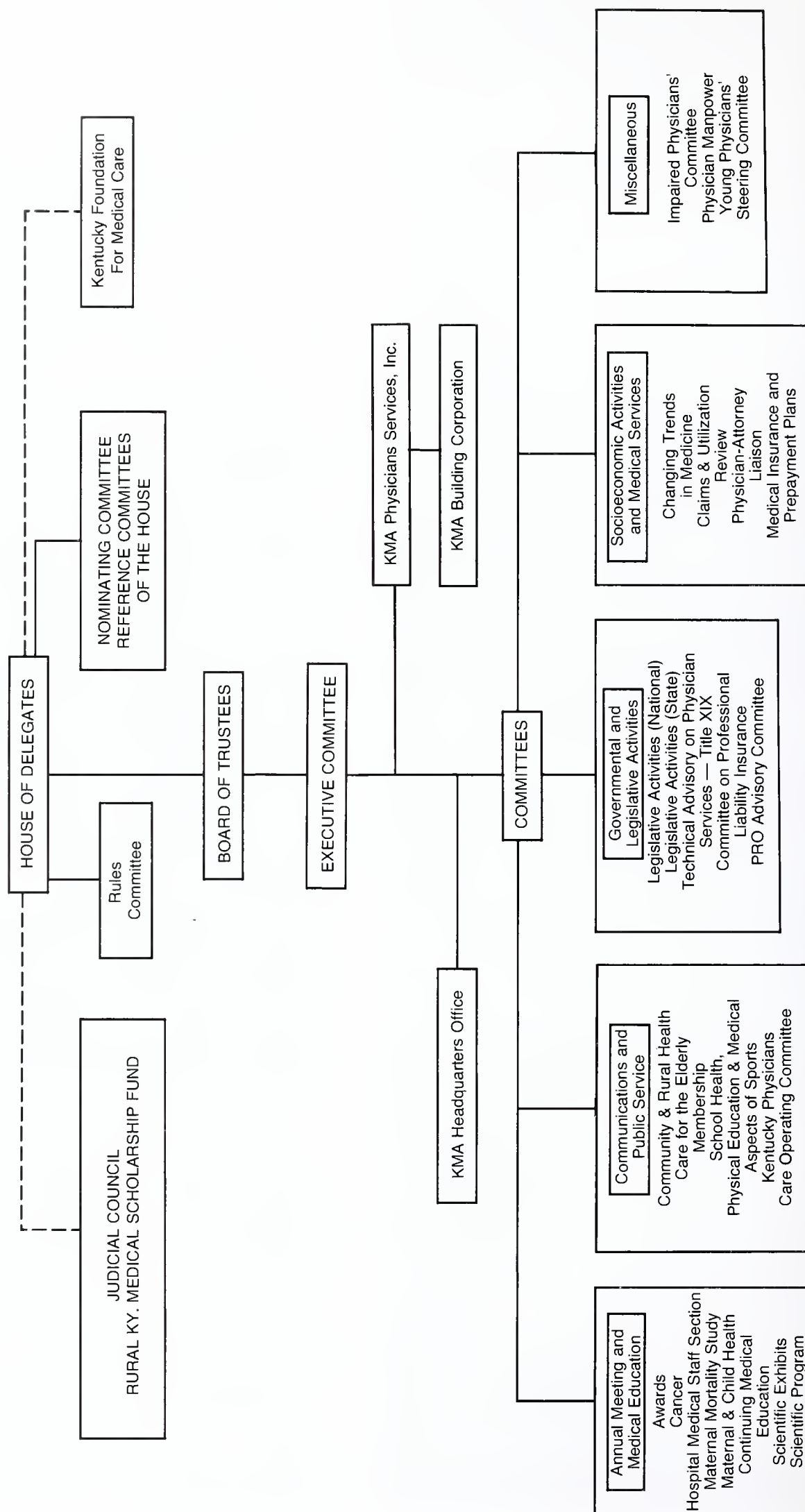
**Section 1.** These bylaws may be amended at any session of the House of Delegates by a majority vote of the Delegates present at a meeting of that session, provided: (1) the amendment proposed is presented in writing to the Delegates thirty days prior to the meeting, or (2) the amendment is introduced in writing at a regular meeting of the House of Delegates during the session and considered at the following meeting of the session, the vote on said amendment having been postponed definitely for a period of at least one day.

**Section 2.** An amendment to or change in the bylaws may be proposed by a reference committee or by the Board of Trustees at the final meeting of a session of the House of Delegates but, not having been postponed definitely for a period of one day, requires a two-thirds vote.

**Section 3.** An amendment to these bylaws may be proposed in writing by an individual Delegate at the final meeting of a session of the House of Delegates. If such an amendment is proposed, the proposal will be postponed definitely and studied by the appropriate reference committee at that time, reporting their recommendation back to the House of Delegates before the final meeting is adjourned. Such an amendment, having not been postponed definitely for a period of one day, requires a two-thirds vote.



# KMA Organization Chart—Revised September 1991



# 1991-92 KMA Committees

## Kentucky Physicians Care Operating Committee

Russell L. Travis, MD, Lexington, Chairman  
 Harry Carlross, MD, Paducah  
 Ray A. Cave, MD, Leitchfield  
 Kenneth R. Crabtree, MD, Gamaliel  
 Alan K. David, MD, Lexington  
 Preston P. Nunnelley, MD, Lexington  
 William P. McElwain, MD, Mouthcard  
 Nelson B. Rue, MD, Bowling Green

## Scientific Program Committee

Sonia R. Teller, MD, Louisville, Chairman  
 J. Greg Cooper, MD, Cynthia  
 William B. Monnig, MD, Edgewood  
 S. Randolph Scheen, MD, Louisville  
 Don A. Stevens, MD, Louisville  
 H. M. Vandiviere, MD, Lexington  
 Gary J. Wahl, MD, Owensboro  
 W. Hal Skinner, MD, Lexington (resident)  
 Brian Schulman, Louisville (student)

## Scientific Exhibits Committee

Richard A. Kielar, MD, Lexington, Chairman  
 James P. Moss, MD, Louisville  
 John W. Ratliff, MD, Lebanon  
 Siby Saha, MD, Lexington

## Awards Committee

Nelson B. Rue, MD, Bowling Green, Chairman  
 Richard F. Hench, MD, Lexington  
 Wally O. Montgomery, MD, Paducah  
 Preston P. Nunnelley, MD, Lexington  
 S. Randolph Scheen, MD, Louisville

## Continuing Medical Education Committee

Larry P. Griffin, MD, Louisville, Chairman  
 Michael E. Daugherty, MD, Lexington  
 Richard D. Floyd, IV, MD, Lexington  
 Robert R. Goodin, MD, Louisville  
 Diller B. Groff, MD, Louisville  
 Michael D. Hagen, MD, Lexington  
 W. David Hager, MD, Lexington  
 J. Bryan Saltz, MD, Ashland  
 Samuel R. Scott, MD, Lexington  
 Thomas K. Slabaugh, MD, Lexington  
 Alfred L. Thompson, Jr, MD, Louisville  
 William P. VonderHaar, MD, Louisville  
 Jim Brown, MD, Louisville (resident)  
 Darin Harden, Lexington (student)

### Ex-Officio:

Ray Leitner, Louisville, KHA Representative  
 Joy Greene, University of Kentucky  
 Gerald Swim, University of Louisville

## Council for Continuing Medical Education

W. David Hager, MD, Lexington, Chairman  
 James L. Borders, MD, Lexington  
 Keith H. Crawford, MD, Paducah  
 Stuart Fink, MD, Louisville  
 Joseph E. Roe, MD, Madisonville  
 Samuel R. Scott, MD, Lexington  
 Paul J. Sides, MD, Lancaster  
 Sonia R. Teller, MD, Louisville  
 Sam H. Traughber, MD, Hopkinsville  
 Larry J. Wilson, MD, Louisville  
 Jim Adams, Jr, MD, Louisville (resident)  
 David Butler, MD, Louisville (resident)  
 Vaughn Payne, MD, Louisville (resident)  
 Phil Budzenski, Lexington (student)

### Ex-Officio:

Joy Greene, University of Kentucky  
 Gerald Swim, University of Louisville

## Cancer Committee

Clinton C. Cook, III, MD, Louisville, Chairman  
 Harry W. Carlross, MD, Paducah  
 Thomas G. Day, Jr, MD, Louisville  
 Gilbert H. Friedell, MD, Lexington  
 Holly H. Gallion, MD, Lexington  
 Harry R. Kennedy, Jr, MD, Somerset  
 Kristie Jones Paris, MD, Louisville  
 Carol S. Milburn, MD, Crestview Hills  
 Condict Moore, MD, Louisville  
 John A. Patterson, MD, Irvine  
 Barbara Phillips, MD, Lexington  
 Steven H. Pursell, MD, Louisville  
 Gary A. Vitale, MD, Louisville

### Ex-Officio:

Martha Hinton, RN, Paducah  
 Wayne B. Miller, Louisville, KY Division,  
 American Cancer Society

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